# RAGHT HRA CONSENT AND RELEASE FORM

**I understand that:**

- The decision to participate in the "Health Risk Assessment" and other screening tests listed below is completely voluntary and not a requirement of my employment;
- There may be slight soreness, tenderness, redness or irritation at the site of the blood draw;
- The data derived from this screening is considered preliminary and does not constitute a diagnosis of diabetes, hypercholestemia, prostate cancer, or hypertension;
- I will be sent a report summarizing all results from the tests completed today;
- If the results from this screening suggest that I may be at risk ("At Risk" as defined below), it is my sole responsibility to contact a medical professional of my choosing for follow-up;
- Participant-specific health screening data compiled from the "Health Risk Assessment" is confidential and will not be released to my employer.

| Screening Tests | "At Risk" Defined | | Recommended Action if "At Risk" |
|---|---|---|---|
| **Health Risk Assessment:**<br>■ Blood Pressure<br>■ Waist Measurement,<br>■ Height, Weight, BMI | Fasting glucose: >100 mg/dL | | Follow-up with personal physician to discuss results; Retest; and/or begin treatment. |
| | Total Cholesterol: >199 mg/dL LDL: >129 mg/dL<br>HDL: <40 mg/dL Triglycerides: >149 mg/dL | | Follow-up with personal physician to discuss results; Retest; and/or begin treatment. |
| ☐ **Fasting Option:** (8 hrs fasting recommended, medications permitted, water encouraged)<br>■ Fasting Blood Glucose<br>■ Lipid Profile & Chem Panel (SMAC) | If blood pressure is between 120/80 and 140/90 on 3 separate occasions it indicates pre-hypertension, and if >140/90 on 3 separate occasions it indicates hypertension. | | Follow-up with personal physician to discuss results; Retest; and/or begin treatment. |
| OR<br>☐ Non-**Fasting Option:**<br>■ Cholesterol, HDL & TC/HDL Ratio | Ideal BMI: Between 19-24.9<br>Waist circumference: Men ≤ 40" Women ≤ 35" | | Follow nutrition and fitness recommendations. |
| ☐ **Prostate Specific Antigen** (Recommended for men 40 & over) | PSA: > 3.9 ng/mL | | Follow-up with personal physician to discuss results; Retest; and/or begin treatment. |
| ☐ **Hemoglobin A1c** | Hemoglobin A1c: > 5.6 | | Follow-up with personal physician to discuss results; Retest. |
| ☐ **Thyroid Tests (TSH, T3, T4, T7)** | Any value out of range on lab report. | | Follow-up with personal physician to discuss results; Retest; and/or begin treatment. |
| ☐ **Colorectal Cancer Screening** Take-home kit for screening. Kit must be returned in provided envelope to Healthwaves | If marked "positive" for presence of occult blood. | GIVEN: ☐ Yes ☐ No<br>INITIALS: | Follow-up with personal physician to discuss results; Retest; and/or begin treatment. |
| ☐ **Optional Consultation:** Brief review of health goals and screening results | | | Given: ☐ Yes ☐ No INITIALS: |

**I hereby:**

**1.** Consent to my blood pressure being measured and to the drawing of a blood sample for the purpose of measuring my selected tests which may include: lipid profile (total cholesterol, HDL, LDL and triglycerides), blood glucose, chem panel (general blood chemistry), Hemoglobin A1c, thyroid profile (thyroid stimulating hormone, T3, T4 and T7), and PSA for men 40 & over.

**2.** Release and agree to hold harmless Rural Arizona Group Health Trust ("RAGHT"), participating entities, Gallagher Benefit Services, Inc. (the Trust's "Health and Wellness Program Management Consultant") Healthwaves Corp., and other organizations, parent and affiliated companies, successors and assigns, officers, directors and employees associated with this screening from any and all liability arising from or related to, or in any way connected with the blood draw and other screening tests performed by Healthwaves Corporation or from the data derived therefrom.

**3.** Give consent and authorization for my results to be released to the Health and Wellness Program Management Consultant, Healthwaves Corp. and American Health Group ("AHG") for follow–up and tracking purposes only. This information will be further compiled in a group summary report that will be sent to my employer; participants WILL NOT be identified individually.

**4.** Consent and authorize my name to be disclosed in relation to the announcement of a wellness incentive, if applicable.

| **Please Print** (mailing address for results): | | | | |
|---|---|---|---|---|
| LEGAL FIRST AND LAST NAME: | PHONE # (DAY): | DOB: | AGE: | SEX: |
| EMAIL: | MAILING ADDRESS: | CITY: | STATE: | ZIP: |
| **EMPLOYER OF PRIMARY INSURED:** | **CIRCLE ONE:** **PRIMARY INSURED** **DEPENDENT** | | NAME AND DOB OF PRIMARY INSURED: | |
| **EXTRA LAB RESULT SHEET (TO GIVE TO PHYSICIAN)** ☐ Yes ☐ No | **DO YOU USE TOBACCO?** ☐ Yes ☐ No | **INFORMATION PAPERWORK** ☐ **DIGITAL** ☐ **PAPER COPY** | **LAST 4 DIGITS SS#** | **INSURANCE MEMBER ID#** |

X _____ _____

SIGNATURE TODAY'S DATE

| **For Healthwaves Personnel Only** | | | | | | |
|---|---|---|---|---|---|---|
| HEIGHT | WEIGHT | WAIST CIRCUMFERENCE | BMI | BLOOD PRESSURE | BLOOD DRAWER INITIALS | **SENT ON / BY** **CONCERN** **A B** |
| | | | | | | |