ASANTE WELLNESS PROGRAM AUTHORIZATION FORM FOR SPOUSE

Your Name _____ **Date of Birth** _____

Asante Employee Name _____

The Asante Wellness Program ("Program") is a voluntary wellness program available to employees and their spouses participating in one of the Asante medical plan options. The Program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

I wish to participate in the Program. By signing this authorization form, I understand I am requesting to participate in one or more of the following tasks:

- **Voluntary Medical Exam.** The medical exam is one or more of the following annual preventive exams that are age-appropriate: adult physical, preventive vision or dental exam, colorectal cancer screen, cervical cancer screen, routine mammogram, routine OB/GYN exam, or an establish care visit.
- **Voluntary Completion of an Interactive Program on Regence Empower.** This task involves completing one or more of the following: Improving Your Blood Pressure, Managing Your Stress, Improving Your Sleep, Achieving Your Healthy Weight, Maintaining Your Healthy Weight; Building Resilience; Enhancing Your Physical Activity, Nutrition for Better Health, Quitting Tobacco, Staying Tobacco Free, Improving Your Oral Health and Financially Fit. This task may involve the disclosure of certain of your medical conditions and certain medical test results.
- **Voluntary Completion of a Personalized Wellness Plan with an Asante Health Coach.** This task may involve the disclosure of certain of your medical conditions and certain medical test results. The Asante Health Coach may work with one or more of your health care providers to support your health care plan.

I have received a copy of a notice from Asante regarding my rights under the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act. I understand that health information, which may include genetic information about me, such as manifestation of a disease or disorder in me or my family members, may be collected during my participation in the Program as described in the notice. I understand that this health information will be used to provide me with results and follow up information to help me understand my current health and potential health risks, and in some cases may also be used to offer me services through the Program.

I understand the Program will never disclose my health information publicly, to Asante, or to my spouse, except as otherwise expressly permitted by law. I understand my health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the Program, and I will not be asked or required to waive the confidentiality of my health information as a condition of participating in the Program or for my spouse to receive an incentive. I understand that my health information may not be used in making an employment decision relating to my spouse, and my spouse will not be discriminated against or subject to retaliation if I decide not to participate in one or more components of the Program or because of the health information I provide.

By signing below, I acknowledge that I am 18 years or older and have read, understand, and accept all of the statements on this Authorization Form, and I knowingly and voluntarily authorize the collection and use of genetic and health information described above for purposes of the Asante Wellness Program until I revoke this consent or no longer am covered under an Asante medical plan option.

Signature _____ **Date**_____