1200 Ridgefield Blvd., Suite 215, Asheville, NC 28806
Phone (828) 670-9145 Fax (828) 670-9159

AUTHORIZATION FOR PARTICIPATION IN HEALTH MANAGEMENT/REBATE PROGRAM

Name ____ DOB: _________________________

Address ____

Daytime Phone ( ) __________________________________ Home/Cell ( ) ________________________________

Email: ____

Employer: ____ Dept: ____

It is my desire to participate in Cherokee County's health management program which entitles me to a rebate of $100 per plan year should I meet the $500 deductible for the plan year. In order to participate, I am returning this form and a copy of my blood work that includes a minimum of a lipid profile (cholesterol and triglycerides) and glucose check and I have had my healthcare provider record my height, weight and blood pressure on my test results.

It is completely your decision whether or not to sign this authorization form. By allowing us to obtain and utilize information from the Health Risk Assessment, we can assist you in achieving your health goals.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed, as provided in this authorization, the recipient will treat as confidential the medical records as defined under the law. For coordination of benefits and services, Crescent may be required to share parts or all of this medical record with the payer of benefits or those authorized to claim administer services.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Participant Print Name ____

Participant Signature ____ Date ___________________________

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

Relationship to Participant ________________________ Print Name ____

Source of Authority ____