

MEDICA CONSENT FORM
Health Club Program Participation

Effective as of _____, 201_, I am choosing to participate in the Fit ChoicesSM by Medica Program (the "Program") offered to me through Medica and Shoreview Community CTR ("Health Club").

If I fulfill the Program requirements, I will be eligible to receive a credit of a portion of my monthly Health Club membership dues from Health Club or its designated representative on behalf of Medica.

I understand that neither Medica nor my employer is responsible if I am injured at a Health Club facility and that neither Medica nor my employer has independently verified that the services that Health Club may provide to me are appropriate for me in light of my fitness condition and state of health.

In the event my employer chooses to pay a portion of my monthly Health Club membership dues, I hereby authorize Medica and Health Club or its designated representative to disclose to my employer the minimum amount of my personal information (sometimes called "protected health information") required by my employer in order to facilitate such payments, in accordance with requirements of federal privacy laws (known as the Health Insurance Portability and Accountability Act of 1996)¹, including my name, address and the number of times I visited a Health Club for the applicable month.

If this consent is made electronically, I understand that I may request a paper copy of this consent. I understand this consent is effective for the duration of my participation in the Program.

Signature

Print Name

Date

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- ¹ I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and would no longer be protected by privacy regulations.
 - I understand I may refuse to sign this consent and my refusal to sign will not affect my eligibility for benefits under any health plan, except to the extent permitted by federal privacy rules.
 - I understand I may revoke this consent by sending a letter to the Fit ChoicesSM by Medica Program Manager at Medica Health Plans, PO Box 9310, Minneapolis, MN 55440-9310. Revocation will stop further use or disclosure of my protected health information except to the extent Medica, Health Club or my employer have already acted in reliance on this authorization. Revocation may also mean I am no longer able to participate in the Program through my employer.