
I hereby authorize Premise Health to use my personal information for the purposes described below ("Premise Health") and to disclose my personal information to the following third parties:

If applicable, by participating in the biometric screening _____

If applicable, by participating in the HRA, you may be asked to complete a voluntary health risk assessment ("HRA") that presents a

Protection of Your Health Information _____

Authorization _____

Effective Time _____

Right to Revoke Authorization _____

Signature and Copy _____

(Participant – Please Print):

