Individual Health Coaching Consent Form and Release of Medical Information

I, ____, as a member, spouse, or legal guardian of the member, agree to participate in the Federal Employee Health Benefit Plan Individual Health Coaching Program administered by Blue Cross and Blue Shield of North Carolina. I understand that this agreement to participate means:

1. I consent to the patient and/or family being contacted by a Health Coach assigned to the case by Blue Cross and Blue Shield of North Carolina.

2. I consent to providers of health care services (hospital staff, physicians, therapist, etc.) being contacted for information about the patient related to the development, implementation and evaluation of an Individual Health Coach Program care plan and for the processing of claims for the services provided under the Program.

3. By my signature below, I authorize the release of medical information for the purpose stated above.

4. I understand that the Individual Health Coaching Program is voluntary and I may withdraw from the program at any time upon notification to Blue Cross and Blue Shield of North Carolina. If I withdraw, my contract benefits, as described in the Service Benefit Plan Brochure will resume.

5. I understand that I should retain a copy of this document for my records and that a photocopy of this form is as valid as the original.

6. I have read the above (or the above has been explained to me) and I hereby agree to participate in Individual Health Coaching Program and am bound by the contractual provisions of my health insurance contract and the guidelines of Blue Cross and Blue Shield of North Carolina regarding the said Program.

This authorization shall expire one year from the date of execution entered above or upon the termination of my health insurance contract, whichever is sooner.

____ ________________________
Patient Name ID

____ ________________________
Member Name and Relationship to Patient Date

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