UFCW Union Local 227 & Employers Health & Welfare Plan

2016 MEDICAL CARE PROVIDER HEALTH SCREENING AUTHORIZATION RELEASE FORM

Valid for screenings through September 30, 2016.

Take this form to a medical care provider. **Please keep copies of all materials submitted.**

By providing the information below and signing this Health Screening Authorization Release form, you acknowledge and agree to the following Terms and Conditions:

- I authorize the sharing of the information collected through the Health Screening on this form with my health plan, the UFCW Union Local 227 and Employers Health and Welfare Plan, for the health care operations activities of the Plan relating to the LiveWell Program.
- I understand that after my health information has been released, the HIPAA privacy rules do not prevent the Plan from re-releasing it, but the Plan may be obligated to keep this information confidential under other applicable law.
- I understand that I have the right to revoke this authorization at any time by sending a written request to the Plan Office. I understand that the revocation will be effective only after it is received by the Plan and the health care provider(s) that perform the Health Screening.
- I understand that I may refuse to sign this authorization and I may revoke this authorization as described above. However, if I do refuse to sign or if I revoke the authorization, I also understand that I may not qualify for the LiveWell better benefit program rewards.
- I understand this authorization expires one year from the date I sign it. I understand that I am entitled to receive a copy of this form. I agree that a photocopy or facsimile of this signed authorization form will be considered as valid as an original signed copy.

PART ONE: PARTICIPANT INFORMATION

NAME:		**EMPLOYER:**		
SEX:	**DATE OF BIRTH:**	**SSN:**		
HOME ADDRESS:		**CITY:**	**STATE:**	**ZIP CODE:**
PHONE:		**E-MAIL:**		

By signing this form, I agree with the health screening results provided below.

X _____ _____

PARTICIPANT SIGNATURE **DATE SIGNED**

PART TWO: RESULTS (Must be completed by a medical care provider)

Is participant's BMI ≤ 29?	**Yes** ☐	**No** ☐
Is participant's fasting blood glucose ≤ 125?	**Yes** ☐	**No** ☐
Is participant's blood pressure ≤ 140/90?	**Yes** ☐	**No** ☐
Is participant's fasting LDL ≤160?	**Yes** ☐	**No** ☐

X _____ _____

MEDICAL CARE PROVIDER SIGNATURE **DATE SIGNED**

Participants must submit the completed form to: UFCW Union Local 227 & Employers Health & Welfare Plan, 10503 Timberwood Circle, Suite 200, Louisville, KY 40223 ● **Phone:** 502-423-8533 ● **Fax:** 502-423-8567