AdventHealth Centra Care

AdventHealth Central Florida Division Health Check Form

Please print and bring this form with you to your next physician visit. It must be filled out completely in order to complete the requirements for the 2020 Wellness Incentive. If you are an AdventHealth Corporate Employee, please log into your WebMD account to access the correct form for corporate employees. This form is only for CFD South and North Employees.

****CONSENT (PAGE 2) MUST BE INCLUDED OR RESULTS WILL NOT BE UPLOADED****

All screenings must be completed and submitted between January 1, 2020 – October 30, 2020.

Complete Section A. Your Physician must complete Sections B and C below.

Section A – Employee Information

First Name:	Last Name:	AH OPID:
Campus Location	Date of Birth:	Phone Number:

Consent to Medical Screening and Release of Medical Information

I consent to release of my medical information as described below to AdventHealth Centra Care and any other companies who offer wellness and associated services to me through AdventHealth. A photocopy of this consent shall be as effective and valid as the original. This consent shall be considered valid for one year from the date signed. I also understand and agree that AdventHealth Centra Care has the right to request, at any time, applicable screening tests.

Employee Signature Date:	Email Address:

Section B: Physician Information

Physician & Practice Name:	Phone #:	Fax #:
Address:		Test Date:

Section C: Test Results

Blood Pressure		Body Measures	
Systolic:	Diastolic:	Height: inches	Weight: lbs.

Clinical Laboratory						
Fasting OR Non Fasting Blood Glucose: mg/dl	Total Cholesterol: mg/dl	LDL Cholesterol: mg/dl	HDL Cholesterol:	Total Cholesterol to HDL Ratio:	Triglycerides: mg/dl	HGBA1C %

Clinical Signature: FORM MUST BE SIGNED BY CLINICAL STAFF

Please send completed form and consent ***by October 30, 2020*** *to*

biometrics@adventhealth.com

OR

Fax results to 407-200-9231 Attn: Andrea Flanagan

AUTHORIZATION AND RELEASE FOR WELLNESS SCREENING

1. I understand that my employer ("Employer") will pay for me to participate in a wellness exam(s) and receive wellness services given by AdventHealth Centra Care ("AHCC"); such other parties that AHCC engages to conduct wellness exams, including AHCC's parent companies, affiliates, subsidiaries, contractors, and third parties; and such other parties that my Employer engages to offer and provide wellness services (collectively, "Wellness Providers"). I understand that my participation in the wellness exam(s) or my decision to receive wellness services is voluntary.

2. I agree to participate in the wellness exam and receive wellness services from the Wellness Providers. I understand the wellness exam will include a health risk assessment and biometric screening, including urine and blood specimen collection and testing in a laboratory designated by the Wellness Providers or my Employer. I understand that the wellness exam is not a medical exam and is not meant to treat or diagnose any underlying medical problem or condition. I understand that it is my responsibility to contact a medical doctor for a complete medical exam and testing and to obtain medical advice on the results of my wellness exam. I hereby release AHCC; my Employer; the Wellness Providers; and all of their respective officers, directors, employees, attorneys, representatives, agents, and affiliates from any and all liability and damages arising out of the wellness exam, including failure of the wellness exam to identify any medical condition.

3. I understand that the Wellness Providers and the laboratory performing the testing and analysis, **will *not* release the results of my wellness screening to my Employer**; however, I agree and consent to the Wellness Providers and the laboratory **releasing non-identifiable, aggregated results** for evaluation, management, and planning of my Employer's wellness program and health benefit program and for public and private reports, presentations, and publications by the Wellness Providers, laboratory, and Employer. I agree that the Wellness Providers and the laboratory may contact me to notify me that medical attention is recommended based upon my wellness exam results or to advise me of other health and wellness programs offered by my Employer or the Wellness Providers. **I give the Wellness Providers and laboratories permission to share information about me from the wellness exam, including the results of my wellness exam, health risk assessment, and biometric screening with my health insurance provider and its parent companies, affiliates, and subsidiaries and third-parties identified by Employer to provide wellness services or other related consulting services to me or my Employer**. The laboratory performing the testing and Wellness Providers may disclose information about me as required by law, subpoena, or court order and may also disclose to contractors and other third parties that are used to support operations of the laboratory and Wellness Providers.

4. I authorize AHCC, the Designees, the laboratory, and Wellness Providers performing the testing and analysis to release the results, information and forms from my wellness exam, health risk assessment and biometric screening, which includes urine and bloods specimen collection and testing, in response to any proceeding commenced by me or on my behalf challenging the wellness exam, health risk assessment, and biometric screening.

5. I hereby release AHCC; the Designees; the laboratory performing the testing and analysis; the Wellness Providers; and all of their respective officers, directors, employees, attorneys, representatives, agents, and affiliates from any and all liability and damages arising out of the wellness exam; health risk assessment and biometric screening; and the communication of the results of the wellness exam, health risk assessment, and biometric screening pursuant to this Authorization and Release ("Release").

6. I have voluntarily signed this Release. I understand that authorizing the disclosure of my health information as described in this Release is voluntary. I can refuse to sign this Release. I understand that AHCC will not condition treatment, payment, or enrollment in any health plans or my eligibility for benefits if I decide not to sign this Release. **If I do not sign this Release, I understand that AHCC will not perform the wellness exam offered by my Employer.**

7. I understand that I may revoke this Release at any time by notifying AHCC in writing, but if I do revoke this Release, my revocation will not have any effect on any actions AHCC took before AHCC received the revocation. I understand that there is potential for information disclosed based on this Release to be subject to re-disclosure by the recipient and to no longer be protected by the Privacy Rule.

I wish to receive information and to be contacted for follow-up regarding any abnormal results at the phone number or email address below. Check One: Yes _____ No: _____	Office Use Only Medical Record#:
Patient Name (Print):	
Name of Legal Representative (Print):	
Signature of Patient (or Legal Representative):	
Telephone:	
Street Address:	Date of Birth:
City: State: Zip:	Today's Date:
Email:	