# Authorization for Use and Disclosure of Health Information

SCREENING AND PHYSICIAN INFORMATION: ***Dependents do not need to complete their biometrics.*** All screening values must be from October 1, 2019 and after. This form must be received no later than September 30, 2020.

**Fax to HealthySteps to Wellness:** 1.650.498.5613 **Attn:** HealthySteps

| Biometric Test | Participant Values | Desirable Values | Biometric Test | Participant Values | Desirable Values |
|---|---|---|---|---|---|
| Total Cholesterol | | <200 mg/dL | Blood Pressure | | <120/80 mmHg |
| HDL Cholesterol | | >40 mg/dL Men<br>>50 mg/dL Women | Heart Rate | | 60-100 bpm |
| TC/HDL Ratio | | <5.0 | Body Mass Index (BMI) | | 18.5-24.9 kg/m² |
| Non-Fasting Glucose | | 70-140 mg/dL | Weight _____ lbs. | | Height _____ In. |
| or | | | | | |
| Fasting Glucose | | 70-99 mg/dL | Notes: | | |

CLINICIAN NAME: (Printed) CLINICIAN'S SIGNATURE: DATE: _____ / _____ / _____

| Full Name: (Printed) | Date of Birth: (mm/dd/yyyy) | Last 4 digits of SSN: | Gender: ___ M ___ F |
|---|---|---|---|
| Work Email: | Phone Number: | Employee ID # | |

| 1. Are you currently pregnant? | 2. Are you taking medication for blood sugar? | 3. Are you taking medication for cholesterol? | 4. Are you taking medication for blood pressure? |
|---|---|---|---|
| ___ Yes ___ No ___ N/A | ___ Yes ___ No | ___ Yes ___ No | ___ Yes ___ No |

5. In general, how would you rate your current health? ___ Excellent ___ Very Good ___ Good ___ Fair ___ Poor

My health information along with other information I have provided as part of the HealthySteps program will be grouped with other HealthySteps participants to conduct aggregate data for analysis and reporting. No identifying information is included in these reports, such as name or employee ID number. **EXPIRATION:** This authorization shall become effective immediately and shall remain in effect until terminated in writing by participant or one year from the date of signing. **RESTRICTIONS:** California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. You have the right to a copy of this authorization and of the health information that you are authorizing for use and disclosure. By signing this form, I authorize the release of my health information from my health care provider to HealthySteps.

SIGNATURE: _____ DATE: _____ / _____ / _____