WELLNESS FIRST
A Division of BHS

EMPLOYEE INFORMATION **PLEASE PRINT CLEARLY**

Company: Air Medical Group Holdings, Inc.

Name: _____

Mailing Address: _____

City, State, Zip: _____

Date of Birth: _____ **SSN:** _____

Age: _____ ☐ **Male** ☐ **Female**

Home #: (**)** _____ **Cell #: (** **)** _____

Work #: (**)** _____

Email Address: _____

☐ **Yes, I fasted for more than 9 hours.** ☐ **No, I did not fast for 9 hours or more.**

PHYSICIAN TO COMPLETE INFORMATION BELOW

TEST COMPLETION DATE: _____

Height: (inches)	**Weight: (lbs.)**	**Waist: (inches)**	**BMI: Body Mass Index**		**Blood Pressure: Systolic/Diastolic (mmHg)**	
Total Cholesterol: (mg/dL)	**LDL Cholesterol: (mg/dL)**	**HDL Cholesterol: (mg/dL)**	**Triglycerides: (mg/dL)**	**Total/HDL Ratio:**	**VLDL: (mg/dL)**	**Glucose:**

SIGNED CONSENT FORM MUST BE SUBMITTED FOR RELEASE OF INFORMATION.

EMPLOYEE SIGNATURE: _____ **DATE:** _____

Please fax form to Sara Chandler at 866-729-9740

Patient Authorization for Use and Disclosure of Protected Health Information

I authorize my health care providers, Wellness First and University Services staff and laboratories that run medical tests for me to use and disclose certain protected health information about me.

The protected health information will be used or disclosed for the sole purpose of complying with state and federal laws. These laws authorize a review and approve laboratory requisitions and review laboratory results.

I authorization my protected health information and laboratory test results to be mailed through the United States Postal Service in order for me, the patient , to receive results to allow me to make informed decisions about my health care.

I understand that I have to receive a copy of this authorization. I understand that I will not be able to receive laboratory testing unless I sign this authorization. I understand I have the right to refuse to sign this authorization. I understand that by signing this authorization I may not be continued to be protected under the HIPPA Privacy Rule. This authorization will expire one year after the date of this authorization.

I understand that this authorization is for my consent to participate in the AMGH Wellness performed by Wellness First and the parties listed above. I have received a copy of this authorization and consent to its terms and representations.

Name:

Signature:

Date:

This signed and dated authorization form must accompany your physician form and lab forms