

## Authorization for Use and Disclosure of Health Information

**SCREENING AND PHYSICIAN INFORMATION:** All screening values must be from **October 1, 2017** and after.

This form must be received no later than **September 30, 2018**.

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 >50 mg/dL Women	Heart Rate		60-100 bpm
TC/HDL Ratio		<5.0	Body Mass Index (BMI)		18.5-24.9 kg/m <sup>2</sup>
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)		Gender: __ M __ F	
Email:			Phone Number:		Employee ID #
1. Are you currently pregnant?  __ Yes __ No __ N/A	2. Are you taking medication for diabetes?  __ Yes __ No	3. Are you taking medication for cholesterol?  __ Yes __ No	4. Are you taking medication for blood pressure?  __ Yes __ No		

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: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Can Stanford Coordinated Care contact you? \_\_ Yes \_\_ No Best daytime phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_