ANNUAL BLOOD WORK & BIOMETRIC SCREENING FORM

PLEASE EMAIL COMPLETED FORM TO HELP@MYACCWELL.COM

ACC EMPLOYEE ID: | **LAST NAME:** | **FIRST NAME:** | **M.I.**

DATE OF BIRTH (MM-DD-YY): – – | **PHONE NUMBER:** – – | **GENDER:** MALE FEMALE

The following two questions provide important information for your glucose & waist circumference measures:

1. Have you been diagnosed with diabetes? YES NO **2. Are you pregnant?** YES NO

Are you able to log activities in your ACC Well account? YES **NO, I need my account (re)activated**

Please read the following statement and sign below to complete this section:

I am voluntarily participating in the biometric screening performed by ACC Wellness. I understand my participation has no impact on my employment. I release ACC Wellness from all liability associated with any aspect of these services. This biometric screening may provide a better understanding of my health and lifestyle. This biometric screening is only educational and not meant to diagnose illness or replace any health care. I will direct questions about a specific illness or condition to my personal physician. ACC Wellness may collect or have access to my Protected Health Information (PHI) e.g., name, date of birth, screening results, etc.) derived from, or related to my biometric screening. I authorize ACC Wellness to disclose my Protected Health Information to Unified Government of Athens-Clarke County designated partners for the administration, development, and evaluation of Wellness initiatives. Otherwise, ACC Wellness will not disclose my PHI except as allowed by Federal and State laws without my express authorization. This authorization is valid until revoked in writing by me, sent to Attn: ACC Wellness, 375 Satula Avenue, Athens, GA 30601. Such revocation is effective upon receipt. My "Acceptance" below confirms I read this form and agree to its terms. Refusing to grant authorization does not affect disclosure of my information otherwise permitted by law. Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws. Except for unlawful uses or disclosure of my PHI, I release and hold harmless my employer, ACC Wellness, and the vendors involved in providing the biometric services described above from liability that may arise from my participation in this biometric screening, except for injuries arising from their respective gross negligence or willful misconduct.

Participant's Signature | **Today's Date** / /

THIS SECTION FOR PHYSICIAN USE ONLY

Weight lbs. | **Blood Pressure Systolic** mmHg | **Total Cholesterol** mg/dl

Waist (around navel) inches | **Blood Pressure Diastolic** mmHg | **HDL Cholesterol** mg/dl

Glucose mg/dl | **Triglycerides** mg/dl | **LDL Cholesterol** mg/dl

Physician's Signature | **Date of Exam (MM/DD/YY)** / /

Physician's Name: | **Office Phone:** – –