AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION AND WAIVER

I understand that my participation in this screening is voluntary and hereby release and hold harmless, my employer, Wellness Consultants, LLC, and any agent or employee of the respective company from any adverse reaction, injury or damage that might result from my screening.

I hereby release and hold harmless, my employer, Wellness Consultants, LLC, and any agent or employee of the respective companies, from liability that may arise on account of any adverse reaction, injury or any other damage which may arise from my reliance on the health screening results, medical information or medically related advice.

I hereby authorize the release of my Private Health Information resulting from my health screening to Wellness Consultants, LLC and any agent or employee of the respective companies. Individual screening results will be kept confidential in compliance with HIPAA guidelines. My employer will not have access to any health related individual results.

I understand that the test results and any educational materials provided to me are for my information only as part of the screening, and this program in no way attempts to propose, diagnose, or recommend medical treatment. I understand it is my responsibility to follow up on the information I receive with my personal physician. I also understand that should I become ill, have any complaints or questions about my health I should contact my usual source of health care.

PLEASE FOLLOW THESE INSTRUCTIONS:

1. Do not eat or drink anything except water or black coffee 6 to 8 hours before your appointment.
2. Limit your alcohol consumption for 24 to 48 hours before your appointment.
3. Please take any morning medications with water.
4. If possible wear short sleeves. This will make it easier to take the blood pressure.

Name (Print)_____

Signature_____

Date_____