Biometric Screening Results Release Form

HNE MEMBERS MUST COMPLETE ITEMS 1 - 6 AND SIGN THE CONSENT FOR RELEASE OF BIOMETRIC SCREENING RESULTS

1. LAST NAME	2. FIRST NAME

3. DATE OF BIRTH *Month/Day/Year*	4. AGE	5. HNE MEMBER ID# *Example: 812345678*	6. SUBSCRIBER ID # *Example: 01*
/ /			

Consent for Release of Biometric Screening Results

I understand that Health New England (HNE) may use my biometric screening information, documented on this form or printed and attached to this form, to provide health management services to me, which includes using this information to inform me of relevant health improvement programs offered by HNE or by another service provider engaged by HNE.

I understand that this information may be imported automatically into my membership wellness account found on the HNE Healthy Directions Web Portal, powered by *Web*MD®. If imported, this information will pre-populate my personal health record and may be necessary for any outcomes-based wellness incentive programs offered by HNE.

I understand that the biometric screening information is meant to be educational and is not meant to diagnose illness or replace normal healthcare. If I have questions about my results, it is my responsibility to consult with my primary care provider or other health professional.

PARTICIPANT NAME *(PLEASE PRINT)* _____

X

SIGNATURE OF PARTICIPANT DATE

ITEMS 7 - 12 AND CERTIFICATION OF BIOMETRIC SCREENING TO BE COMPLETED BY THE HNE MEMBER'S PROVIDER

7. PROVIDER LAST NAME	8. PROVIDER FIRST NAME
9. DATE OF SCREENING	10. PROVIDER LOCATION
11. HEIGHT Feet Inches	12. WEIGHT *(Pounds)*

13. LIPID PANEL	ENTER RESULTS	UNITS	14. GLUCOSE	ENTER RESULTS	UNITS
A. TOTAL CHOLESTEROL		mg/dL	A. FASTING		mg/dL
B. HDL CHOLESTEROL		mg/dL	B. NON-FASTING		mg/dL
C. LDL CHOLESTEROL		mg/dL	15. BODY MASS INDEX (BMI)		
D. TRIGLYCERIDES		mg/dL	16. BLOOD PRESSURE Systolic Diastolic		

Certification of Biometric Screening Results

To the best of my knowledge, I certify that the listed biometric screening results above are accurate and complete.

PROVIDER NAME *(PLEASE PRINT)* _____

X

SIGNATURE OF PROVIDER DATE

Please mail the completed form to:
Health New England
One Monarch Place, Suite 1500
Springfield, MA 01144-1500
Attention: Health Management Program Department

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HNE Health New England