American WellBody Program
Eagan Center for Wellness
Street Address: 1500 32nd Avenue North, Birmingham, Alabama 35207
Mailing Address: Eagan Center for Wellness, P.O. Box 2727, Birmingham Alabama 35202-2727
Telephone: (205) 307-2745 Facsimile: (205) 325-4701

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

(Please Print)

Participant Name_____		
Badge Number _____	Department _____	Date of Birth: _____

I, the above-named Participant, hereby authorize and request *(print name of health care provider)* _____("Health Care Provider") to disclose to the ACIPCO Wellness Program, including any of its employees and agents ("Wellness Program"), the following medical information about me:

(Check all that apply)

- ☐ Laboratory Reports (including blood glucose and lipids)
- ☐ Blood Pressure Reading(s)
- ☐ Body Weight & Height
- ☐ Other *(explain)* _____

I also authorize my Health Care Provider to discuss my released medical information with the Wellness Program staff. A copy of this Authorization may be used in place of and with the same force and effect as the original.

By providing this Authorization, I understand as follows:

1. That this Authorization is voluntary. I may refuse to sign this Authorization and my enrollment or eligibility for benefits under the ACIPCO Medical and Dental Plan will not be affected.

2. That the health information to be released may be subject to re-disclosure by the recipient of the health information and no longer protected by State and Federal privacy rules.

3. That I may revoke this Authorization at any time by notifying the Health Care Provider and the Wellness Program in writing, but such revocation by me will have no effect on disclosures of information already made under this Authorization prior to the receipt of my revocation.

4. That I will receive a copy of this Authorization form after I sign it.

5. That this Authorization will expire at the end of my participation in programs and my receipt of services offered by the Wellness Program.

_____ _____
Signature of Participant Date

_____ _____
If under 19, signature of parent or guardian Date