HealthWorks
Building Healthy Worksites

PHYSICIAN FORM

To be completed by patient:

Patient Name: _____

DOB: _____

Employer: _____

Email: _____

Phone #: _____ Last 4 of SSN#: _____

Home Address (Street, City, State, Zip): _____

_____

Release of Information:

I, _____ (patient name) grant permission to Dr. _____(physician name) to share the lab results below, blood pressure, height, weight, and waist circumference measurements with Healthworks. I understand that my information will not be shared directly with my employer and that HealthWorks adheres to all HIPAA regulations.

Patient Signature: _____ Date: _____

Patient Results (To be completed by physician)

Fasting: Yes_____ No _____ Tobacco User: Yes _____ No _____

Pregnant: Yes _____ No _____ Diabetic: Yes _____ No _____

Test	Glucose	Total Cholesterol	HDL	LDL	Triglycerides
Result					
Test	**A1-C (if applicable)**	**Blood Pressure**	**Weight**	**Height**	**Waist Circumference**
Result					

Physician Signature: _____ Date: _____

REQUIRED (please print):

Physician Name: _____

Phone: _____

Address: _____

_____

This form can be:

1. Emailed to: offsite@cincyhealthworks.com
2. Faxed to: (513) 672-2060
3. Mailed to: Healthworks
   3914 Oak St.
   Cincinnati, OH 45227

*Please Note: This MUST be sent by physician's office