WESTERN WISCONSIN HEALTH

Western Wisconsin Health
Consent for Screening

Name:_____ _____ Date:_____

- This health screening consists of measuring blood pressure, height, and weight and drawing blood through finger stick testing to determine total cholesterol, HDL, and blood sugar. If I have been fasting, LDL cholesterol and triglycerides will also be measured. This health screening may also include other health assessments that I may choose to receive as well.
- The health screening will be performed by a qualified technician/personnel. I understand this health screening is informational only and does not constitute medical care or diagnosis. I understand I should see my qualified health professional for diagnosis of any health problems I may have.
- The purpose of the health screening is to help me become more aware of my personal health status and to help me connect with wellness resources in my community. As part of the feedback I receive from the screening, I may receive recommendations to make modest changes in my lifestyle (e.g., healthy eating, physical activity, no tobacco use, limiting alcohol use, stress management) or be referred to my medical provider.
- I understand emergency equipment and trained personnel are available to handle any unusual situations that may arise. I understand there may be minor discomforts associated with drawing blood and that I may feel brief pain at the time my finger is pricked to draw blood. I voluntarily assume all risks associated with this health screening.
- All questions which have arisen or occurred to me have been answered to my satisfaction, and I voluntarily consent to participate in the health screening.

Authorization for Release and Use of Data

- The information obtained during the health screening will be treated as confidential and will not be released or revealed to any person without my express written authorization.
- I authorize the use of my health screening results for purposes of the screening program, including evaluating my health and determining the need for community health resources.
- If the health screening is part of a corporate wellness screening for my employer, I authorize WWH to share data from my health screening, in aggregate data form only (with no personal identifiers), with my employer.
- I further understand that WWH may access my information in order to provide recommendations to me about my health or make me aware of medical providers, community resources, events, or activities that can assist me in improving my health, and I authorize WWH to use my information this way.
- I understand that this authorization for the use and disclosure of my health information will not expire unless I revoke it by giving written notice to WWH.

By signing this consent form I understand and agree to the statements above.

Signature:_____ Phone: _____

Address: _____

Witnessed by:_____