See the Reasonable Alternative section below which must be initialed by the physician .

Name: ________________________________

Last 4 of SSN: __________________________

Employer: Copley-Fairlawn City Schools

Dear Doctor:

Your patient is participating in a Wellness Initiative through their employer. Part of this initiative involves obtaining routine screening measures and sharing them with our Wellness Company. This health information is *not* shared with the patient's employer and we respect all elements of confidentiality.

If you have any questions about the screening process or wish to discuss any elements of the program, we invite you to call Be Well Solutions at (216) 378-0888 and speak to our Medical or Wellness Directors.

Thank you in advance for helping your patient.

Ronald Golovan, MD, FAACP
Medical Director

Michael Schechter, MD
Wellness Director

Release of Information:

I, _____________________ grant permission to Dr. _________________ to share certain elements of my health information,
(patient name) (doctor's name)
specifically laboratory results (cholesterol and glucose measurements), blood pressure measurements, height and weight, with Be Well Solutions. This release will be in effect for two years from the date signed. I understand I may retract this permission at any time either verbally or in writing. Information will not be shared directly with my employer. Be Well Solutions, Inc. is a bona fide wellness company and adheres to all such limitations and regulations.

Patient signature: ______________________
Date: ______________________

Patient Results:

My patient has had a physical between July 1 - November 30, 2024 (Circle One): Yes No

Lab Date: ____________________ Fasting (Circle One): Yes No Diabetic (Circle One): Yes No

Glucose	Total Cholesterol	LDL Cholesterol	HDL Cholesterol	Triglycerides	Blood Pressure	Height	Weight	BMI

REASONABLE ALTERNATIVE

I have discussed these results with the above-named patient who is under my care for any risk factors associated with *glucose, cholesterol, blood pressure and BMI.* We will continue to work on these issues on an on-going basis.

****REQUIRED FOR CREDIT, MUST BE INITIALED BY PHYSICIAN**** *Physician's Initials* _________

THIS FORM CAN BE:

Returned to the patient who must send it to Be Well Solutions. Return to BWS no later than December 1, 2024.
Emailed to: info@bewellsolutions.com
Faxed to: (440) 498-1366
Mailed to: Be Well Solutions
30625 Solon Rd. Suite C
Cleveland, OH 44139

REQUIRED (please print):
Physician Name: ____________________________
Phone: ____________________________
Address: ____________________________
____

Physician Signature ____________________________