

corphealth

Name:

Address:

Date of Birth:

Member ID #:

Date:

To: Corphealth, Inc.

10816 Executive Center Drive, Suite 206, Little Rock, AR 72211

RE: Request and Authorization to release the following information on my behalf:

This release of information is requested for the sole purpose of verifying my participation in the Corphealth weight management program(s). I further understand that verification of this information is a prerequisite for my participation in the food replacement weight management program offered by my employer.

I _____, hereby authorize Corphealth, Inc. to release information regarding my participation in the HealthMedia Balance™ and/or HealthMedia Nourish™ weight management program(s) to the Arkansas Employee Benefits Division (EBD), Health Services Department, 501 Woodlane, AEGON Building, 5th Floor, Little Rock, AR 72201.

Member's Signature

Date

FOR OFFICE USE ONLY

Programs completed: (check all that apply)

- HealthMedia Balance™ program with health coaching
 HealthMedia Nourish™ program with health coaching

This member has participated in the weight management program(s) HealthMedia Balance™ and/or HealthMedia Nourish™ since _____, which has been for a time period of at least three months, and has completed all five health coaching calls.

Health Coach

Date

Wellness Dir/VP, Arkansas Operations

Date