

# LifeSynch

Name:

Address:

Date of Birth:

Member ID #:

Date:

To: LifeSynch

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 LifeSynch 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 LifeSynch 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

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## 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