HEALTHCARE PROVIDER FORM

STEP 1: Complete the participant section.

STEP 2: Ask your provider to complete their designated section.

STEP 3: Fax forms directly to HealthSource Solutions at 763-287-0789 or upload them HERE by **December 15, 2025.**

These forms cannot be submitted via email or in-person.

Form must be fully completed and legible to be processed.

PARTICIPANT SECTION

Date of Birth: _________/_________/_________ Gender (check one): ☐ Male ☐ Female

First Name: ______________________________ Last Name: ______________________________

☐ Employee ☐ Spouse (if spouse) Name of employee: ______________________________

Signature:____

Email Address:____

I hereby authorize my health care provider to release the following health data to Healthsource Solutions.
By signing this form, I agree with the health screening results provided below.

HEALTHCARE PROVIDER SECTION

Total cholesterol: ______________________ ☐ Fasting ☐ Non-fasting

HDL cholesterol: _______________________ Blood pressure (mm/hg): __________/__________

Triglycerides: __________________________ Height (ft. in.):______________________________

LDL cholesterol: ________________________ Weight (lbs):_________________________________

Glucose (mg/dl): _______________________

Health care provider's signature:____

Health care provider's printed name:____

Date: ______/______/_____

HealthSource Solutions