

## PREVENTIVE CARE CAMPAIGN FORM

DATE OF EXAM  PHYSICIAN'S SIGNATURE  PRINTED NAME OF PHYSICIA  NAME OF PRACTICE  STREET ADDRESS  CITY  STATE, ZIP CODE  Please return completed form to employee  For Questions Telephone:	My employer, Connecticut Attorneys Title Insurance Company (CATIC), sponsors a voluntary wellness program in which I have chosen to participate. The program focuses on preventive care and provides an incentive for employees who receive a preventive care physical exam deemed appropriate by their physician.  I hereby authorize	EMPLOYEE SECTIO	N: Employee Authorization to I	Release Personal Health Information
wellness program in which I have chosen to participate. The program focuses on preventive care and provides an incentive for employees who receive a preventive care physical exam deemed appropriate by their physician.  I hereby authorize	wellness program in which I have chosen to participate. The program focuses on preventive care and provides an incentive for employees who receive a preventive care physical exam deemed appropriate by their physician.  I hereby authorize	Dear Health Care Prov	rider:	
PROVIDER] to disclose the personal health information outlined below to my employer.  EMPLOYEE'S SIGNATURE PRINTED NAME OF EMPLOYEE  PHYSICIAN SECTION: Physician's Verification of Preventive Care Examination Visit  This patient visited my office on the date indicated below for a preventive care examination that I deemed appropriate based on patient's age, gender and medical history.  DATE OF EXAM PHYSICIAN'S SIGNATURE PRINTED NAME OF PHYSICIANAME OF PRACTICE  STREET ADDRESS  CITY  STATE, ZIP CODE  Please return completed form to employee  For Questions Telephone:	PROVIDER] to disclose the personal health information outlined below to my employer.  EMPLOYEE'S SIGNATURE PRINTED NAME OF EMPLOYEE  PHYSICIAN SECTION: Physician's Verification of Preventive Care Examination Visit  This patient visited my office on the date indicated below for a preventive care examination that I deemed appropriate based on patient's age, gender and medical history.  DATE OF EXAM PHYSICIAN'S SIGNATURE PRINTED NAME OF PHYSICIA  NAME OF PRACTICE STREET ADDRESS CITY STATE, ZIP CODE  Please return completed form to employee  For Questions Telephone:	wellness program in wl care and provides an ir	hich I have chosen to participate. ncentive for employees who receive	The program focuses on preventive
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Jesenia Pagan at: 860- <i>257-0606 (ext. 3122)</i>	Jesenia Pagan at: 860- <i>257-0606 (ext. 3122)</i>	This patient visited my I deemed appropriate to DATE OF EXAM  NAME OF PRACTICE STREET ADDRESS CITY STATE, ZIP CODE	office on the date indicated below based on patient's age, gender an PHYSICIAN'S SIGNATURE	v for a preventive care examination that nd medical history.
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