Impact Health Sharing

AUTHORIZATION
FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

First Name | Last Name | Membership ID

Permissions to Discuss Medical History, Records or Conditions

1. I authorize the disclosure of protected health information, including but not limited to, medical records, reports, medical bills, pharmaceutical records, diagnostic test results, and lab test results.
2. I understand that the following parties will receive this information regarding my membership in the sharing program: Impact Health Sharing ("Impact"), its employees and authorized agents.
3. Those parties that receive protected health information may disclose it for purposes of treatment, payment, or operations of Impact. They may otherwise disclose information only as allowed or authorized by law. These parties include insurers to which proposed member has applied or may apply, pharmacy benefit managers, physicians, hospitals, clinics or other medical related facilities, health care clearing houses or persons who perform tasks for them.
4. I understand that this protected health information is needed to verify eligibility of my bills submitted to Impact.
5. Unless revoked earlier, this authorization will be valid as long as I am enrolled in Impact plus 18 months from the date my membership ends.
6. I understand that I may revoke this authorization at any time by notifying Impact in writing at the address shown below, but if I do, it won't have any effect on any actions taken prior to receiving the revocation.
7. I understand that this authorization is voluntary; I understand that I may get a copy of this form after signing it.
8. I understand that if an organization I authorize to receive the protected health information is not a health plan or healthcare provider, federal or state law may no longer protect the released information and it will no longer be private.

Signature (Parent's signature if member is under 18) | Date

Printed Name of Member | DOB of Member