IM Health

HIPAA Privacy Authorization Form
Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1.Authorization

I authorize my labs and/or healthcare providers (including my doctors' offices) to use and disclose the protected health information described below to the IM Health organization only during the effective period below.

2.Effective Period

This authorization for release of information covers only the period of healthcare from:

- **12 months prior to the start of the enrollment in the IM Health program, until 36 months after completion of the program.**

3.Extent of Authorization

- **I authorize the release of BLOOD WORK LAB RESULTS AND OTHER PHYSICAL HEALTH BIOMETRICS (i.e. HEIGHT, WEIGHT, BMI, BODY FAT %, BLOOD PRESSURE, ETC.) RESULTS ONLY**. No other medical records (including diagnosis, treatment, procedures, medications, etc.) will be released without my prior written permission.

4.This medical information may be used by the person I authorize to receive this information for consultation, billing or claims payment, or other purposes as I may direct.

5.I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6.I understand that my payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

By clicking "I agree" I am electronically signing and authorizing IM Health to get copies of my blood test mentioned above during the effective period.