IMP Physicians
The Future of Healthcare

I have read and understand the HIPAA/Privacy Policy for IMP (copy available on request).

I authorize IMP to release to my insurance company medical information required to process claims.

I hereby assign my insurance benefits to be paid directly to the healthcare provider.

I have read and understand the financial/office policies for IMP (copy available on request).

I authorize IMP to obtain/have access to my medication history through medical history authority.

I authorize IMP to contact me by the means I have selected (i.e. telephone, text, email).

I authorize IMP to use Impact SIIS for reporting vaccines I receive to the State of Ohio Department of Health. *(This is for our office inform the Ohio Department of Health when you receive a vaccine.)*

☐ Yes ☐ No

I authorize IMP to exchange my healthcare information with my other healthcare providers through an encrypted electronic data exchange. *(This is for us to be able to send your medical information when we refer you to another doctor.)*

☐ Yes ☐ No

I authorize IMP to take photographs and use those images taken for diagnostic and treatment purposes. *(For example, your provider may take a picture of a mole or rash in order to determine at a later date if the condition has improved or progressed.)*

☐ Yes ☐ No

My primary care provider is _____ in the _____ office.

My signature implies consent to the above statements.

Signature _____ Date _____

Printed Name _____ Date of Birth _____