

Health Record Consent

Membership Number _____

Personal Details

Legal First Name	Legal Last Name
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Primary Member

Spouse

Parent Child (<18)

Child (18+)

Reason for Consent

In order for us to proceed with your membership, The Health Bank will need to record and store details of your health information. These details will contain your personal and sensitive data.

In compliance with the applicable laws, we must tell you how we use this data and ask for your permission. By signing this form, you are providing your permission for us to process your data for the purposes below. For further information, please see our Terms of Data Protection, which can be found in Addendum B.

Permission to Store Your Data

We are required in many cases by international law to ask for your permission to record details of a personal and sensitive nature. Where no Data Protection laws exist, The Health Bank will apply best practice as its benchmark (i.e. The General Data Protection Regulation (EU) 2016/679), to protect your stored data. This data will be stored in a shared electronic health management system only accessed by authorized members of The Health Bank. Paper copies of your data may also be stored securely by The Health Bank.

Please sign next to your selection below:

_____ Yes – I/We give my/our consent to The Health Bank to record sensitive personal and health information about me/us

_____ No – I/We give my/our consent to The Health Bank to record sensitive personal and health information about me/us

Permission to share your data with other service providers

Everything you tell us will be treated confidentially, however, under the terms of your membership, we may be required to go to specialist organizations in order to provide these services, which may include organizations situated outside of the UAE/ Pakistan where necessary. Ideally, we would only give them the relevant information needed to facilitate their services. By giving consent below, you are agreeing that The Health Bank may release necessary information, to enable referral or schedule appointments on your behalf, with other providers.

Please sign next to your selection below:

_____ Yes – I/We give my consent to The Health Bank to share my personal information with other service providers under the terms of my membership agreement.

_____ No – I/We do not give my consent to The Health Bank to share my personal information with other service providers under the terms of my membership agreement.

Member Acknowledgement

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the patient health data to be disclosed. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by The Health Bank. However, we will always obtain assurances from the recipient to protect your private health data to the same standard as we do.

I understand that I have the right to refuse this authorization and that my membership will not be conditioned on signing. This authorization shall be in effect until revoked by the member.

If signing on behalf of a dependent.

I _____ declare that I have disclosed all particulars relevant to this application, and I warrant that I am authorized to sign on behalf of my dependent.

Note: This is a system generated document and does not require signature.

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