



In order to qualify for a Health Discount, each adult (except adult children age 18-22) must be enrolled in Medi-Share 2.0, submit a test kit and meet the health requirements. If either adult is a mandatory health partner, they are not eligible for the discount.

1. Contact Information

Primary Head of Household Name: _____

CCM ID Number: _____ Phone Number: _____

Ship to: Address: _____

City: _____ State: _____ Zip: _____

2. HbA1c Test Kit Request (Cost for one kit is \$25. Each additional kit is \$23.)

Number of test kits requested: _____

3. Authorization for Use/Disclosure of Health Information

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct the CCM designated lab ("Lab") to disclose the below-described health information during the term of this authorization to Christian Care Ministry, Inc., 505 N. John Rodes Blvd., Melbourne, FL 32934.

Purpose and Information to be Disclosed: I understand that the specific purpose of this Authorization is to allow Lab to provide the results of test(s) done on samples of my blood to Christian Care Ministry, Inc., and I hereby authorize Lab to disclose such results.

Term: This Authorization will remain in effect until Lab fulfills this request.

Print Name Print Spouse Name (if applicable)

Signature Date Spouse Signature Date

Please make additional copies of this form if requesting kits for more than 2 people.

4. Payment

Total Payment: _____

Check or Money Order made payable to Christian Care Ministry

Please charge my: Visa MasterCard

Card # - - -

Expiration Date / 3 digit security code