AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize any physician, medical practitioner, hospital, pharmacy, pharmacy benefit manager, health information exchange, health plan, health insurance plan, health care provider or health care facility, health care professional, clinic, laboratory, medical facility or any other entity that has any diagnosis, prescription or other medical information about me, to disclose my entire medical record and any other protected health information to:

IBU, Inc
157 Church Street 19th Floor New Haven, CT 06510

This authorization shall apply to any and all individually identifiable health information, including medical records, reports, pharmaceutical records, drugs, diagnostic testing, and lab work. I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/ drug abuse, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), Human Immunodeficiency Virus (HIV) or ARC and my past medical history including pharmaceutical / prescription records, drugs and diagnostic testing.

This authorization shall be valid for 24 months from this date, or the time limit permitted by law in the state where the policy is issued. I understand that I may revoke this authorization at any time by writing to IBU, Inc 157 Church Street 19th Floor New Haven, CT 06510. I also understand that revocation will not apply to information that has already been released as specified by this authorization.

I have a right to receive a copy of this authorization. I understand I have the right to refuse to sign this authorization. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient, may be electronically transmitted, and may no longer be protected by HIPAA or any other health information privacy laws. I hereby release and hold harmless the above-named facility and any parent company from all liability and damages resulting from the lawful release of my protected health information. Treatment, payment, and enrollment or eligibility for benefits will not be conditioned upon signing authorization. A copy of this authorization may be considered as valid as the original.

Name:	*Date of Birth:*	*SSN:*
Signature		*Date:*