AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

This authorization gives myBlueHub your permission to acquire your health information under your guidance.

I, , authorize you to use and/or disclose my health information as identified below to me through my myBlueHub account provided by BlueHub Health, Inc for the purpose of maintaining and sharing my record with my providers.

For information on how to deliver my record to my myBlueHub account, please visit www.bluehubhealth.com/requested or fax my record to: 1-877-991-9643

I authorize the release of my complete health record, specifically the use or disclosure of the following health information and/or records:

- The entire medical record (all information)
- All hospital records (including nursing records, progress notes, discharge summaries)
- Transcribed hospital reports
- Medical records needed for continuity of care
- Clinician office chart notes
- Diagnostic imaging reports
- Laboratory Reports
- Pathology/biopsy reports
- Emergency and urgent care records

I authorize the release of my complete health record including the following information:

- Mental Health Records information and/or records
- HIV/AIDS related health information and/or records
- Genetic Testing information and/or records
- Drug/Alcohol diagnosis, treatment and/or referral information

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 consent a claim. Unless revoked earlier, this authorization will expire in 180 days from the date of signing.

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

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This Authorization is digitally signed by:

Signature of Individual or Individual's Legal Representative

Date