Wholesure Life & Disability

Authorization for Disclosure - HIPAA Compliant

I hereby authorize each physician, doctor, physician practice group, nurse, pharmacy, pharmacy benefit managers, insurance support organizations, medical information service including Medical Information Bureau, Inc. and ABX Management, hospital, clinic, and/or any other health care provider ("Authorized Disclosure") to provide to Wholesure Life & Disability Practice and/or its affiliates, directors, officers, employees, service providers, or other representatives noted below ("Wholesure Life & Disability Practice"), any and all information and/or records as to diagnosis, treatment, and/or prognosis (including any and all dates thereof) concerning my past, present, or future physical or mental history or condition and other non-medical information (including, but not limited to, personal financial information). I also specifically authorize each Authorized Disclosure to release to Wholesure Life & Disability Practice the results of any HIV or AIDS test as well as information relating to any sexually transmitted diseases, drug or alcohol abuse, and psychiatric evaluations and/or information.

I understand that all medical information disclosed hereunder will be treated as confidential and will only be used by Wholesure Life & Disability Practice in connection with the decision to purchase, finance, transact a insurance settlement, and/or maintain one or more insurance policies under which I am insured. I further understand that I am not required to sign this Authorization in order to obtain healthcare benefits (treatment, payment, or enrollment).

I understand I have the right to revoke this Authorization in writing at any time by sending a written request of revocation to: 23 Vreeland Road, Suite 180, Florham Park, NJ 07932. I understand that this revocation is not effective to the extent that (i) the Authorized Disclosure has taken action in reliance upon this Authorization prior to receiving notice of my revocation or (ii) if this Authorization was obtained as a condition of obtaining insurance coverage, other law provides an insurer with the right to contest a claim under an insurance policy.

I understand that this Wholesure Life & Disability Practice is not a health care provider, health care clearinghouse, or health plan covered by privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Privacy Regulations"). I further understand that, as a result of this Authorization, any of my medical information disclosed by any Authorized Disclosure to Wholesure Life & Disability Practice may be redisclosed by Wholesure Life & Disability Practice to the following recipient parties: other insurers to which the Proposed Insured has applied or may apply; reinsurers; MIB; or persons or organizations that perform business, professional, or insurance tasks for them. I also understand that some information may be disclosed to persons or organizations that are not subject to federal health information privacy laws, which means that the information may no longer be protected under such laws. But even if information is disclosed to persons or organizations that are not subject to federal health information privacy laws, those persons or organizations must comply with all other applicable legal requirements governing the protection and redisclosure of information.

I certify that I am executing and delivering this Authorization freely and unilaterally as of the date written below and that all information contained herein is true, accurate, and correct. I further certify that this Authorization is written in plain language and I fully understand its contents. I will retain a signed copy of this Authorization for future reference.

I specifically authorize and request my insurance company and each Authorized Disclosure to rely upon a photostatic or facsimile copy or other reproduction of this Authorization the same as the original.

This Authorization shall remain valid until, and shall expire 36 months from the signature date.

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Printed Name _____ Signature _____

Date of Birth _____ Social Security Number _____ Date _____