AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

I hereby authorize disclosure of protected health information about me as follows:

PATIENT NAME	
PATIENT ADDRESS	
PATIENT PHONE	
PATIENT DATE OF BIRTH	

Persons/Organizations authorized to disclose medical information about me:

DOCTOR/ OFFICE (Name, Address, Phone)	
HOSPITAL (Name, Address, Phone)	

The information may be disclosed to:

Broadspire
P.O. Box 14349
Lexington, KY 40512-4349
Phone: 866-874-2865
Fax: 866-225-0044

I agree that Broadspire may also disclose this information to Stryker Orthopaedics and to service providers who are working under contract to Stryker Orthopaedics, Broadspire, or their affliliated entities, to assist with the evaluation and review described in this form.

The specific information to be disclosed is x-rays or other radiology films and related reports, operative report, medical records, and implant sheet, medical history, and office notes.

Date From (surgery): to Date End: Present

The purpose of the requested disclosure is to evaluate whether certain costs related to my medical treatment associated with the recall of the Rejuvenate Modular or ABG II Modular are eligible for reimbursement.

I acknowledge that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by Federal Law.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency (HIV);

sexually transmitted disease, tuberculosis or genetics. IF YOU DO NOT WISH THIS INFORMATION TO BE RELEASED, PLEASE INITIAL. DO NOT RELEASE___.

I have the right to revoke this authorization by written notice to Stryker Orthopaedics, or Broadspire. I understand that actions in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

If I do not sign this form, it will not affect how my health care providers treat me. However, if I do not sign, verification of my claim may be delayed until the required documentation can be obtained or my request for reimbursement of incurred medical expenses related to this claim may be denied.

This authorization expires 12 months from the date of signature below.

I acknowledge that I do not waive my rights to pursue legal action by signing this form or by disclosing this information

_____ _____

Signature of Patient or Personal Representative

Date of Signature

If signed by a personal representative, a description of the representative's authority to act is as follows: