HIPAA COMPLIANT
AUTHORIZATION FROM INDIVIDUAL
FOR RELEASE OF MEDICAL RECORDS

Purpose: This form is used to confirm the direction of an individual that Provider use or disclose the individual's protected health information for a particular purpose.

SECTION A: The Individual (or the Individual's Personal Representative) confirming the authorization.

I authorize the use and/or disclosure of my protected health information as described in Section B below. I understand this authorization is voluntary and made to confirm my direction.

I understand that, if the persons or organizations I authorize below to receive and/or use the protected health information described below are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Name: _____

Address: _____

Telephone: _____ Date of Birth: _____

Social Security Number: _____ Purpose: **Legal**

SECTION B: The use and/or disclosure being authorized.

Protected Health Information to be Used and/or Disclosed: Specifically and meaningfully describe the protected health information you are authorizing be used and/or disclosed

1. My patient file, including, but not limited to, patient history, office charts, progress notes, diagnostic test results, x-ray or laboratory reports, surgical reports, consultation reports, pathology reports, specimens and/or slides, correspondence, drug and alcohol testing and treatment, and any other document pertaining to me.
2. Any and all records relating to my medical treatment, including, but not limited to, documents relating to office visits, hospital visits, medical tests, and any medical, or surgical treatments.
3. Any and all x-rays, MRI's, CT scans, ultrasounds or other radiological or sonographic studies.
4. My billing file, including any charges and payments for office visits, procedures, hospital visits, laboratory tests, x-rays, medication, and any other treatment for which charges were incurred.

Entities Authorized to Use or Disclose: Name or specifically identify the persons or organizations (or the classes of persons and/or organizations), including Provider, who you are authorizing to make use of and/or to disclose the protected health information described above: This Authorization is voluntary. Pursuant to the Privacy Rules, the provider may not condition treatment, payment, or eligibility for benefits on whether the patient signs this authorization.

Medical records from _____, 20___ to present from:

Entities Authorized to Receive and Use: Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations) to whom you are authorizing Provider to disclose and/or let use the protected health information described above:

Faegre Drinker Biddle & Reath LLP, Attorneys and/or Their Representatives
320 South Canal Street, Suite 3300
Chicago, IL 60606-5707
Telephone: (312) 569-1000
Facsimile: (312) 569-3000

SECTION C: Expiration and Revocation.

Expiration: This authorization will expire (complete one):

☐ On _____/_____/_____ (DD/MM/YR).

☐ On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized: **At the conclusion of litigation between _____ v. Exactech, Inc., et al.**

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: Faegre Drinker Biddle & Reath LLP

Telephone: (312) 569-1000 Fax: (312) 569-3000

Address: 320 South Canal Street, Suite 3300, Chicago, IL 60606

I acknowledge the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer be protected under HIPAA privacy rules.

SIGNATURE.

I, _____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to the Provider. I understand that, by signing this form, I am confirming my authorization that the Provider may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature: _____ Date: _____

If this authorization is signed by an individual's personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.