

**Authorization to Use or Disclose Information
(Medical Release Form)**

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization or persons authorized to receive the information is not a health plan or health care provider, then the released information may no longer be protected by federal privacy regulations.

Patient Name:	
Patient Address:	
Patient Date of Birth:	

Persons/organizations providing the information (Doctor/Office Name or Hospital and Address):

Persons/organizations receiving the information:

DePuy Orthopaedics, Inc., Customer Quality Department
PO Box 988, 700 Orthopaedic Drive, Warsaw, IN 46581

Specific description of information to be used or disclosed, including date(s):

All medical records and x-rays of (name) regarding his/her initial implant surgery that occurred on or about (date), and subsequent revision surgery that occurred on or about (date), and all follow up visits and records. Doctor office records should include but not be limited to new patient intake form, progress record, telephone message slips, copies of lab work, radiography, consultation reports, physical therapy reports, product code and lot number of components implanted; and all records relating to these surgeries and all follow up visits and records.

Reason for use or disclosure of information: Manufacturer's Investigation

- I understand that I will not be denied health care or health plan coverage, as the case may be, if I do not sign this form.
- I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.
- I understand that this authorization will expire six months from date of signature.
- I understand that I may revoke this authorization at any time by notifying the person or organization providing the information in writing, but if I do it won't affect any actions taken before the revocation is received.

Signature of Patient or Patient's representative

Date