



## Authorization for Release of Patient Information Gel-One® Cross-linked Hyaluronate Insurance Verification

The purpose of this Authorization Form is to allow me to release some of my protected health information, as described below, to a medical device company named Zimmer Inc., so that Zimmer can assist my doctor in verifying (confirming) that my health insurance company will pay for a new treatment called *Gel-One* Hyaluronate that my doctor is considering for one or both of my knees.

_____ Patient's Name	_____ Date of Birth	_____ Physician's Name	
_____ Patient's Street Address	_____ City	_____ State	_____ Zip Code

I understand that this authorization is voluntary. I understand that my health information is protected by certain federal privacy laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules, and the Health Information Technology for Economic and Clinical Health Act (HITECH), as well as certain state laws. Although those laws do not apply in the same way to the medical device company that will receive my information, I understand that the recipient will nevertheless take steps to safeguard my information from unauthorized access, loss, misuse, alteration or destruction.

I understand that my physician will only disclose to Zimmer the health information that is relevant for Zimmer to verify insurance coverage. This includes my name, address, date of birth, insurance information, whether I have had *Gel-One* Hyaluronate treatments in the past, and whether one or both knees are identified by my doctor for treatment. My doctor will not release other portions of my medical record.

I also understand that Zimmer may discuss some of my health information with my health insurance company for purposes relating to verifying (confirming) my insurance coverage for the *Gel-One* Hyaluronate Product. I recognize that my health insurance company already has most of this information about me (such as my name, contact information, and insurance coverage information) by virtue of providing health insurance to me, and that my health insurer is required to comply with federal and state privacy laws (including HIPAA and HITECH) to protect my data.

I understand that my physician will not condition his/her treatment of me on whether I sign this form. Signing is purely voluntary, and is intended only to help verify whether my insurance company will cover the *Gel-One* Hyaluronate treatments that my doctor is considering for me.

I understand that I may revoke this authorization at any time by notifying my doctor or Zimmer in writing. Zimmer's address is: Gel-One Hyaluronate Insurance Verification Team, 1108 W. Center St., P.O. Box 708, Warsaw, Indiana, 46580. I may also call Zimmer at (866) 966-0444. However, the revocation will not have an effect on any actions that my doctor or Zimmer took before it received the revocation.

**I authorize my physician to provide my health information to the Zimmer Insurance Verification Team as follows:**

- The information from my medical record that my doctor deems appropriate for the purpose of allowing Zimmer to assist in verifying insurance coverage for my use of *Gel-One* Hyaluronate.
- The dates of the information will be determined by my doctor, as relevant to the insurance verification.

