

Authorization to Share Health Information

I _____, allow my doctor(s), my health plan or insurers, and any other healthcare providers to give medical information relating to my use of need for the REALIZE™ Adjustable Gastric Band to Lash group Healthcare Consultants. Lash Group Healthcare consultants run the Ethicon Endo-Surgery Reimbursement Support Program.

This information can include spoken or written facts about my health or payment benefits I may have. It can include copies of records from my healthcare providers or health plans about my health or care.

Lash Group Healthcare consultants will use and give out this information to check to see if I have coverage for the REALIZE™ Adjustable Gastric Band and to run the Program. Lash Group Healthcare Consultants may also give my information to others if they first take out anything that identifies me.

I know that people who work for and with Lash Group Healthcare consultants may use and see my information, but they may use it only as allowed in this form. I understand that Lash Group Healthcare Consultants will make every effort to keep my information private, but if it is accidentally given out, federal privacy laws will not protect it.

This Authorization will last for 3 years after the date I sign this form. If I change my mind before that time, I can tell my doctor, healthcare provider, and/or my insurer in writing that I do not want them to share any more information with Lash Group Healthcare Consultants, but it will not change any actions they took before I told them. I know that I have a right to see or copy the information my healthcare providers or insurers have given to Lash Group Healthcare Consultants.

I KNOW THAT I MAY REFUSE TO SIGN THIS FORM. My choice about whether to sign this form will not change the way my healthcare providers treat me. If I refuse to sign this form, I know that this means I may no longer be able to receive assistance from the Program.

I understand that Lash Group Healthcare Consultants does not promise to find ways to pay for my REALIZE™ Adjustable Gastric Band surgery, and I know that I may have to pay the costs of my care.

Patient Sign Here _____ Date _____

(If the patient cannot sign, patient's representative must sign below)

Patient Name: _____

(Signature of person signing for patient)

Describe relationship to patient and right to act for patient:
