

Authorization for Use and Disclosure of Protected Health Information

USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION: United States Federal Privacy Regulations now in place address the sharing of a person's medical record information. Under these regulations, you have certain privacy rights regarding the use and disclosure of your private medical information. This private medical information is called Protected Health Information, or PHI.

By signing this form, you are authorizing the use and disclosure of your PHI collected by your doctor in connection with your treatment with the ZERONA System. Your information will only be used and disclosed in accordance with the provisions of this consent form and applicable law.

What Information Will Be Used or Disclosed?

Your PHI related to your treatment with the ZERONA System includes, but is not limited to, information in your medical records, your billing records, and any information you gave to your doctor that was used for your ZERONA procedure. This information will include information that will identify you (your name, address, etc.). An example of PHI associated with your ZERONA procedure is your body measurements and completed questionnaires.

How Will this Information Be Used?

Your PHI will be given to Santa Barbara Medical Innovation, or SBMI, and its agents to be used to evaluate your potential entitlement to a ZERONA system promotional warranty.

Who May Obtain, Use, or Disclose this Information?

The parties who will be authorized to use and/or disclose this information are limited to the following:

- Your doctor who performed the ZERONA treatment
- SBMI and its agents

Length of Authorization

Your authorization for the use and/or disclosure of your PHI will be in effect for 90 days from the date this authorization is signed by you. During this time SBMI and its agents will evaluate your PHI to determine if you are entitled to a promotional ZERONA warranty.

You may withdraw your permission to use your PHI, except to the extent that the law allows these parties to continue using your information.

Is My PHI Protected After it Has Been Given to SBMI?

By signing this authorization, your PHI will no longer be protected by federal privacy laws that protect your PHI.

By signing this form, you authorize the use and disclosure of your Protected Health Information to the parties listed for the purposes described above.

Patient Name _____ Date _____

Patient Signature _____

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