AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize **[insert name of health care provider] (the "Provider")** to disclose Protected Health Information ("PHI") about me to DePuy Orthopaedics, Inc. (the "Company") for research associated with the development of joint replacement products as described in this Authorization. The PHI required for this research may include name, date of birth, diagnosis, gender, left or right bone identification, radiographic images, height, weight, case/lot number, implant device type, varus/valgus profile, femoral bow angle, flexion angle, flexion contracture, impingement angles, final implant sizing, bone resection amounts, planned implant rotation angles, tibial slope, cartilage loss, boney landmarks, and date(s) of my surgery(ies). I understand that these data points are measurements that are required for the proper design and manufacturing of the device. The Company will only disclose my PHI to its authorized agents and affiliates who assist in the analysis of the data collected during this research, such as product development associates and research study investigators. Additionally, the Company may disclose my PHI as required by law, such as in response to a valid subpoena or for reporting of safety issues**.** Information that may directly identify me will be removed from the data prior to engaging in research. The data may be retained for (i) the length of time the "Company" has an ongoing relationship with you and provide the Service to you, (ii) whether there is a legal obligation to which the Company is subject, and (iii) whether retention is advisable in light of the Company's legal position (such as in regard to applicable statutes of limitation, litigation, or regulatory investigations. I understand that if the company collects my personal information for the manufacturing of my TRUMATCH Patient Specific Instrument, the Company will store such information for a period of twenty-five (25) years from end of marketing of product by DePuy Orthopaedics, Inc. Further, I understand that this is not an exhaustive list of retention periods, and that my personal information may be stored for a longer period using the criteria set forth above.

Specifically, the TRUMATCH™ manufacturer and those working with it may use my anonymized data to:

- Share the data and derived reports with regulatory agencies, such as the U.S. Food and Drug Administration, that approve and audit medical devices.
- Analyze it to increase understanding of the medical device and treatment results. Re-analyze the results of the research at a later date and combine them with results of other studies.
- Use it with data from comparable cases for analytics/research purposes and to learn more about such and similar diagnoses and treatments.
- Use it to improve medical community knowledge related to such and similar diagnoses and treatments.
- Publish summaries of cases' data in medical journals, on the internet or present cases' data at meetings for other researchers to learn about the conditions, diagnoses and treatments.
- Use it to investigate new treatments, interventions and management procedures so that patient care outcomes are continually improved.
- Evaluate the data to be used for internal analytical, development and research purposes. The information may be used to improve surgical techniques, materials, and protocols for joint replacement.

I understand that:

- I may ask my healthcare provider any questions I have about this document prior to signing it, and have done so.
- I may refuse to sign this Authorization and not participate in the research. I do not have to sign this Authorization to receive treatment.
- The PHI shared with the Company may no longer be protected by federal privacy regulations after it is disclosed by my healthcare providers.
- If I change my mind, I may revoke this Authorization in writing at any time by contacting my health care professional. I understand that any revocation will not apply to PHI that has already been used and disclosed in response to this Authorization.
- If not earlier revoked, this Authorization will expire at the conclusion of the research.
- I have the right to review the PHI that has been disclosed to the Company upon written request to my health care provider.
- I affirm that I am a person over the age of eighteen (18) years, or am the parent or legal guardian of a minor, who is legally authorized to consent on behalf of the minor.

I authorize the use and disclosure of my Protected Health Information as described above.

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Signature of Individual or Personal Legal Representative *Date*

If a personal legal representative is signing the form on behalf of the individual whose medical information is to be used or disclosed, please print the name of the personal representative and describe his or her authority to act on behalf of the individual.

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Print Name of Personal Representative

_____

Describe the basis for the Personal Representative's authority (e.g. Power of Attorney dated MM/DD/YYYY and attach document.)