Patient Authorization for Use or Disclosure of Protected Health Information to Rollins Advocacy & Consulting, LLC

I, _____ , hereby authorize Dr. _____ to disclose health information about me specific to my lower back pain to the activL® Artificial Disc Patient Assistance Line (PAL), administered by Rollins Advocacy & Consulting. I authorize the PAL and Rollins Advocacy & Consulting to use my protected health information solely for the purpose of pursuing insurance coverage for an artificial disc replacement with the activL Artificial Disc.

This authorization will expire one year from the signed date or at the completion of the appeal process, whichever comes first. I understand that I may revoke this authorization at any time, even if it has not expired, by giving a written notice to my doctor. I understand that my revocation will become effective on the day it is received by the doctor's office.

Rollins Advocacy & Consulting may only use and disclose your health information pursuant to its policies and procedures relating to patient information, which are designed to protect against any improper use or disclosure of your health information.

_____	_____
Patient Signature *Date*	*(or) Authorized Representative* *Date*
_____	_____
Print Name	*Print Name* *Relationship to Patient*
_____	_____
Patient Phone Number	*Authorized Representative Phone Number*

Please fax the completed form to the activL Patient Assistance Line at 844-285-1330.