TENON Group®

7752 Cooley Lake Road
Waterford, MI 48327
Office 248.360.9952
Fax 248.360.6142
mr@tenon-group.com

Authorization to Release Information

I hereby authorize Tenon Group® PC to communicate with and obtain information from my treating physicians and other health care providers, healthcare insurance payors, medical institutions and related entities and individuals about my past and future medical care, and related billing and payment specifics, including obtaining copies of my medical, and billing and payment records. This authorization is for the purpose of completing a future medical cost projection, Medicare set aside services and related purposes as it relates to my accident or injury occurring on _____.

I hereby authorize my treating physicians and other health care providers, healthcare insurance payors, medical institutions and related entities and individuals, to release my personal health information as described above to Tenon Group® PC for the purpose set forth above. The information to be released may include my entire medical file, office notes, diagnostic test reports, lab reports, history, physical, admission and discharge summaries, physical therapy notes, consultation reports, operative reports, histories and profiles, psychiatric records, prescription records, bills, and all other forms of documents pertaining to my medical treatment and/or hospitalization and records of charges, payments, estimates, costs, and recommendations relating to the foregoing.

The persons or entities authorized to receive and use my personal health information are:

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I also authorize Tenon Group® PC to disclose information about my benefits, to confirm my entitlement status and to confirm any claim payments that may have been made.

I may revoke this authorization at any time by notifying **Tenon Group® PC** in writing, sent to the above address, of my desire to revoke it. I understand that any action already taken in reliance on this authorization cannot be reversed and my revocation will not affect those actions. I understand that the company or individual to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization. The authorization will expire when the purpose for which my information was requested by Tenon Group® PC has been completed.

I understand that information used or disclosed may be subject to re-disclosure by the entity receiving it and would then no longer be protected by federal privacy regulations.

Print Name: _____

Sign Name: _____

Date: _____

A photocopy of this authorization shall be considered as effective and valid as the original. **Note:** A copy of this signed form must be given to the person signing it and can be obtained by contacting Tenon Group® PC at the address and phone number shown above.

Note: If the authorization is signed by a personal representative of the individual, a description of such representative's authority to act for the individual must also be provided.