

**Eclipse Orthopaedic Rehab  
750 Terra Cotta Avenue, Ste D  
Crystal Lake, IL 60014  
815 444-8037**

**Patient Name:** \_\_\_\_\_

**I understand that, under the Health Insurance Portability & Accountability Act of 1996 I have certain rights to the privacy regarding my protected health information. I understand that this information can and will be used to – conduct, plan, and direct my treatment and follow up among the multiple healthcare providers who may be involved in my treatment directly and indirectly. This information can be used to obtain payment from third-party payers and conduct normal healthcare operations such as quality assessments and physician certifications. I understand that Eclipse Orthopaedic Rehab reserves the right to modify the privacy practices outlined in this notice. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent. I also have read the Financial Policy provided by Eclipse Orthopaedic Rehab and understand and accept the policy. I understand that it is my responsibility to address any outstanding claims on my account.**

**RELEASE OF INFORMATION**

**I hereby authorize Eclipse Orthopaedic Rehabilitation to release all medical information to:**

**Name of Carrier(s) and attorney for the purpose of claims administration and evaluation, utilization review and financial audit.**

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Signature:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_