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PRIVACY PRACTICES

**PLEASE SIGN AND RETURN ONE COPY
IN THE ENCLOSED ENVELOPE**

Keep the remaining copy for your records.

I, _____, my
Name of Insured – Please Print

Medicare number or Insurance Plan Name and Number being:

Medicare Number or Insurance Plan Name and ID Number

Understand that my signature on this agreement authorized ReBuilder Medical Technologies, Inc. to obtain and release information regarding my medical history, testing, treatment, or other medical information that is relevant to my acquisition and use of the ReBuilder.

ReBuilder Medical Technologies, Inc. will exchange my medical information with authorized representatives of health insurance companies, government entities, or other providers of medical care.

This agreement for obtaining and releasing my medical information will remain in effect until I, or my Legal Representative, revoke the agreement in writing to ReBuilder Medical Technologies, Inc. via hard copy delivered mail to the address on this letter.

I understand that once ReBuilder Medical Technologies, Inc. releases my medical information, the continued privacy of the information is not within their control.

Signature of Insured / Beneficiary

Date