BARR CENTER FOR INNOVATIVE PAIN & REGENERATIVE THERAPIES

Authorization to Disclose Protected Health Information

Patients Name:		
DOB:	**Daytime Phone:**	**Cell:**

The requested medical information may be disclosed to and used by the following individual(s) or organization:

Name:	**Relationship:**	**Phone #:**	**For the purpose of:** (please circle all that apply)
1.			**Medical Insurance Other**
2.			**Medical Insurance Other**
3.			**Medical Insurance Other**

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time by notifying Barr Institute for Innovative Medicine & Regenerative Therapies in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise **revoked**, this authorization will **expire one year** from the date this form is signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I **do not** need to sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524.

I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by Federal confidentiality rules. If I have questions about disclosure of my health information, I may contact the Privacy Officer at Barr Center for Innovative Pain & Regenerative Therapies in person and/or I may request a read a more detailed version of Barr Center for Innovative Pain & Regenerative Therapies Notice of Privacy.

Patient/Guarantor (Please Print)	**Patient/Gaurantor (Signature)**	**Date**
Witness (Please Print)	**Witness (Signature)**	**Date**