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HIPAA PRIVACY AUTHORIZATION FORM
Authorization for use or disclosure of protected health information

Dr. Daniel L. Burkhead at Innovative Pain Care Center is committed to HIPAA regulations. Therefore each patient is required to sign a release. Patients may include companion(s) (family members, friends, ect) accompanying them to their appointment, schedule or reschedule appointments. Listed individuals are approved to hear discussion regarding the patient's health information.

I authorize the following individuals to be involved in the discussion of my medical health information. I understand I am responsible for the release of information provided by Innovative Pain Care Center to the following:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

X _____
Patient Name **Date**