Authorization for Disclosure of Health Information and Medical Records Release

1. *I authorize the use or disclosure of health information as well as the release of medical record information as described below in the treatment of my neuropathic pain.*

2. *The following individual or organization, and its affiliates, its employees and agents are authorized to make the disclosure and release of medical records:*

   Name of physician / institution: _____

   Address: _____

3. The type and amount of information to be used or disclosed is as follows:

   Health records related to diagnosis in the treatment of neuropathic pain

   Lab results/X-ray/MRI reports

   Physical exam

   Consultation reports

   Medications

   Emergency Room visits, Hospitalizations

   Other (please specify: _____

4. *The health care information relevant to neuropathic pain may be disclosed to and used for the purpose of treatment and collection of data for the purpose of (a) Calmare® Site Certification with the Calmare® Scrambler Therapy MC5A device; and (b) for obtaining medical information during my Calmare® Scrambler Therapy treatments in the event of an adverse event, emergency room visit, and/or hospitalization.*

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to CTTC Privacy Officer. 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 for disclosure of health information and medical release of records will expire on the following date, event, or condition: _____.

   I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. If I have questions about disclosure of my health information, I can contact:

   Competitive Technologies, Inc.
   Sarah Kinley, Privacy Officer
   5113 Piper Station Drive
   Charlotte, NC 28173
   704.544.5999 office
   704.544.5976 fax

_____
Printed name of patient or legal representative

_____ _____
Signature of patient or legal representative Signature of witness

Date: _____ Date: _____

Formatted 8.2011 AM
Revised 2:07pm 8.30.2011 AM

PLEASE NOTE: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC – 3701.243) and federal law 42 CFR, part II.