Authorization for Release of Patient Information

Richard N. Brown, MD
1441 Redbud Blvd, suite 261
McKinney, TX 75069
Phone 972-562-1388
Fax 972-562-1344

Name of Patient: _____ Date(s) of Service: _____
Date of Birth: _____ Social Security Number: _____
I, the undersigned, authorize the release of or request access to the information specified below from the medical record(s) of the above-named patient.

Patient Information Is Needed For:

__Continuing Medical Care __Military __Social Security/Disability
__Insurance __Personal Use __Legal Purposes __School
__Other: _____

Information To Be Released Or Accessed:

__History & Physical __Consultation Report __Emergency Room Record
__Operative Reports __Discharge/Death Summary __Face Sheet
__Lab/Pathology Reports __X-ray Reports/Images __Other: _____

_____
(name of medical facility/doctor, address, phone/fax numbers)

May release the above information to Richard N. Brown, MD. I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition as follows:

Date: _____ Signature: _____
Patient or Legally Authorized Representative

_____
Printed Name of Patient or Legal Representative

_____
Relationship to Patient