AUTHORIZATION TO RELEASE MEDICAL RECORDS TO:
BRIAN M. BROWN, M.D.

NAME: ____

ADDRESS: ____

SSN: ______________________ DATE OF BIRTH: ______________

I hereby authorize and request any physician indicated below:

PHYSICIAN/HOSPITAL NAME: ______________________________

ADDRESS: ____

TELEPHONE: ____

To release my complete medical history records in your possession to:

Brian M. Brown, M.D.
10933 Lakewood Blvd. Downey, CA 90241
TEL: 562-904-1989 FAX: 562-904-0416

Medical records should include copies of the physician's charts/notes as well as results of any laboratory or diagnostic tests performed in the last 24 months.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility provider, insurance company, or other organization, institution or person, that has any records or knowledge of me or my health, or any of my legal dependents' health to release such information to Brian M. Brown, M.D.

A photographic copy of this authorization shall be recognized as valid and as the original. This consent may be revoked at any time upon written request executed by the undersigned and directed to the release, except to the extent that the action has been taken in reliance thereon. The authorization will expire 12 months after the date of signing this form. The information used or disclosed under the authorization may be subject to re-disclosure by the recipient and no longer protected by the HIPAA rule.

Authorization must be signed by the patient or authorized a representative of the patient.

Patient/Parent or Legal Guardian: ________________________ ____________

Signature Date