MEDICAL RECORDS PROCESSING AUTHORIZATION FORM

NAME: _____

ADDRESS: _____

SSN: _____ DATE OF BIRTH: _____

I hereby request/authorize Brian M. Brown, MD Inc. to release my Medical Records (MR) **to**:

Name of person/facility to receive MR: _____

Address: _____

City, State & Zip Code: _____

I understand and agree to pay a $25 fee processing. I further understand that medical records include copies of the physician's charts/notes as well as results of any diagnostic testing's performed at the offices of Brian M. Brown, MD only.

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 whom I have named about as the recipient.

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 The consent can be withdrawn at any time upon written request executed by the undersigned and directed to the release, except to the extent that the action has been taken in reliance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

Patient must sign an authorization or authorized representative of the patient.

Patient/Parent or Legal Guardian: _____ _____

Signature Date