**Stephen E. Brown, MD, PLLC**

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

|  |  |  |  |
| --- | --- | --- | --- |
| Patient’s Name: |       | Date of Birth: |       |
| Parent/Guardian: |       | Social Security #: |             |

|  |  |
| --- | --- |
| **I request and authorize:**  |       |
| (Provider releasing records) |  |
| Address: |       | City: |       | State: |    | Zip: |            |
| Office Phone: |               | Office Fax: |               |
| **to release healthcare information of the patient named above to:** |
| (Entity receiving records) |       |
| Address: |       | City: |       | State: |    | Zip: |            |
| Office Phone: |               | Office Fax: |               |

**This request and authorization applies to:**

|  |  |
| --- | --- |
| [ ]  Healthcare information relating to the following treatment, condition, or dates: |  |
|  |  |
| [ ]  All healthcare information |
| [ ]  Other: *(explain)* |       |

|  |
| --- |
| I specifically authorize the release of the following types of highly confidential information:  AIDS or HIV, Mental Health History and Treatment, and Sexually Transmitted Diseases.I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to: Stephen E. Brown, MD, PLLCI understand that signing this authorization is voluntary and that Stephen E. Brown, MD, PLLC, may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization.I understand that information disclosed based on this authorization may be subject to re-disclosure by the recipient, and no longer protected by federal or state privacy regulations.I have received a copy of this authorization. |
| Patient Signature: |  | Date: | 6/19/2008 |

**THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED**