Authorization for Use or Disclosure of Information

I, _____, hereby authorize Richard N. Brown, M.D. ("the Provider") to use or disclose the following protected health information:
(Specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.)

_____

_____

The above information is to be used only for purposes outside the routine transference of information, i.e., other providers, insurance companies, billing companies, etc. The most likely use of this information would be for Attorneys, other family members, employers, etc.

The protected health information may be disclosed to: *(Insert name of person or entity who may receive the information)*

_____

This protected health information is being used or disclosed for the following purposes: *(List specific purposes here, the patient may indicate that the information to be disclosed is "at the patient's request" if the patient does not choose to provide an explanation of the purpose of the request)*

_____

_____

_____

This authorization shall be in force and effect until: (check one of the following)

Date _____

- ☐ The happening of the following expiration event:

  _____

  _____
- ☐ End of research study
- ☐ No expiration (can only be used if authorization is for creation of research database or research repository)

at which time this authorization to use or disclose this protected health information expires.

I understand that, as set forth in the provider's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to:

Richard N. Brown, M.D.
1441 Redbud Blvd., Suite 261
McKinney, TX 75069
ATTN: Privacy Officer