Katherine Brown, M.D.
Obstetrics & Gynecology
(503) 693-0113 Fax: (503) 681-4773
P.O. Box 4330, Hillsboro, OR 97123

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name_____ **(Maiden)** _____
Address_____
_____
Telephone_____**Date of Birth**_____
SSN_____ **ODL #**_____

I authorize Katherine Brown, M.D. to RELEASE my medical records to:
Provider/Clinic Name_____
Address_____
Telephone_____ **Fax** _____

For the purpose of:
□ **Continuing medical care**
□ **Leaving the Area**
□ **Request from Insurance company**
□ **Request from school/college or employer**
□ **Self**

This request and authorization applies to:

□ **All Medical Records**	□ **Progress Notes**
□ **Operative Reports**	□ **Radiology & Imaging Reports**
□ **Pathology Reports**	□ **Laboratory Reports**
□ **Most recent 2 years**	□ **Records for the following dates or treatment: _____**

I understand that my specific consent is required to release any health care information relating to testing, diagnosis, and/or treatment for certain problems listed below. By placing my initials in the applicable space next to the type of information, I understand and agree that the information **may be released**.

(Initials)_____ HIV/Aids
_____ Sexually Transmitted Diseases
_____ Psychiatric Disorders/Mental Health
_____ Drug and/or Alcohol Use
_____ Genetic Screening and Testing

I may cancel this release at any time by notifying the record holder in writing. My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon this authorization. I release the clinic/provider and its entire staff from all legal responsibility that may arise from this release of information. I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment. A copy of Katherine Brown, M.D. Privacy Notice has been offered to me. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it. **Signature must match signature on record for documents to be released.**

Signature: **Date:**

This authorization shall begin immediately and remain in effect until_____or not more than 180 days from this date.