Lori D. Brown ND, MA
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Authorization for Release of Medical Information

Patient Name: ____

Phone: ___________________________ Birthdate: ______________________

Please complete as much of the following information as you know:

From: ____
Doctor or Clinic Name

____
Street Address

____
Phone Number   Fax Number

To: Dr. Lori Brown—Natural Family Medicine
16701 SE McGillivray Blvd., Suite 265, Vancouver, WA 98683
Phone: 360.882.1339
Fax: 360.253.8006

I understand that my consent is required for the release of my medical records under state and federal law. I hereby consent to the release of all information noted below to be used for my continued healthcare:

___ Chart Notes from ____________________to ____________________
___ Laboratory Results from _______________to ____________________
___ Imaging Reports from ________________to_____________________
___ Other: ____

to not include disclosure of health care information regarding testing, diagnosis, and treatment for (check any health information to NOT be disclosed):

___ HIV (AIDS virus)   ___ Sexually transmitted diseases
___ Psychiatric/Mental health   ___ Drug and/or alcohol use

I understand that I do not have to sign this authorization in order to get health care benefits. I may revoke this authorization in writing but such revocation would not affect any actions already taken by Dr. Lori Brown or Natural Family Medicine based upon this authorization. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the named recipient, and may no longer be protected by HIPAA's privacy rules after the authorized disclosure.

Unless I request in writing otherwise, I understand that this authorization will expire on ______________. If I do not specify an expiration date or event, this authorization will expire ninety (90) days from the date on which I signed this authorization.

Signature of Patient or Legal Guardian: _________________________ Date: _________

Relationship (if signed by a representative): ___________________________________