AUTHORIZATION

I authorize Douglas C. Brown, M.D., A Medical Corporation, to release my medical records to my spouse, members of my family and/or a legal or personal representative as indicated below. I understand the person(s) named on this authorization will be given access to obtain or review my records and have my permission to discuss my care or obtain results/information on my behalf. This authorization extends only to the person(s) I have identified below. I may revise this decision in writing at a later date, if I so choose.

Name	Relationship	Telephone Number	Birth Date

Patient's Signature _____ Date _____

I do not authorize release or disclosure to my spouse, family members or any personal representative at this time. I may revise this decision in writing at a later date, if I so choose.

Patient's Signature _____ Date _____