Kevin E. Brown, M.D.
702 Mangrove Ave., #341
Chico, CA 95926
Phone: (530) 899-2107

Patient Authorization for Use and Disclosure of Protected Health Information FROM Dr. Brown TO another person or party

TO____ PHONE________________

FAX:____

ADDRES____

CITY, STATE, ZIP____

By signing this form I authorize Kevin E. Brown M.D. and Argyll Medical Group to use and/or disclose any and or all types of individually identifiable health information about me (Protected Health Information), or I may specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level etc except as specified below:

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The information will be used or disclosed for purposes at the discretion of the requesting party, or for other purposes if specified below:

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The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

I do not have to sign this authorization in order to receive treatment from Dr. Kevin E. Brown or the offices of Argyll Medical Group. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Kevin E. Brown M.D. in writing at: 702 Mangrove Ave., #341 Chico, CA 95926

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Signature of patient or legal guardian Date Relationship to patient

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Print name of patient , and of legal guardian if used Print birth date of patient