AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize use or disclosure of protected health information about me as a described below .

The following specific person or class of persons or facility is authorized to make the requested use or disclosure:

Patient's Name: ______________________________

Patient's Address: ______________________________

Patient's Phone Number: ____________________ **Patient's Date of Birth:** ____________

Dear Dr. **DOUGLIS,**

Please send my Records to:

____

NAME OF DR. / FACILITY

____

ADDRESS OF DR. / FACILITY

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TELEPHONE AND FAX NUMBER OF DR. / FACILITY

Specific description of information to be released:

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Your Physician will provide this information within *15*-business day from the receipt of authorization. Your physician may ***charge a reasonable fee for preparing and furnishing*** this information according to rulings set forth by the Texas State Board for Medical Examiners.

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

I may revoke or withdraw this authorization by notifying Dr. Franklin M. Douglis in writing of my desire to revoke it. However, I understand that any action already taken in advance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me or whether or not I sign the authorization.

This ***Authorization will expire 30 days*** from the date of the signature unless otherwise requested in writing.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

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Signature of Individual Date of Signature

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Signature of Guardian Date of Signature Description of Guardian's Personal Representative's Authority to Act for the Individual