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. ____,

ADDRESS OF DR. / FACILITY ____

TELEPHONE & FAX NUMBER OF DR. / FACILITY ____

Please send my Records to: ***FRANKLIN M. DOUGLIS, MD, P.A.***

Preferred method: Email: *earnosethroatallergysnoringcenter@allmedsdirectmail.com*

3000 West Davis
Conroe, Texas 77304
(936) 539-9322 Fax (877) 489-3077

Specific description of information to be released:

____

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.

Signature of Patient ____

Date of Signature ____

Signature of Guardian (if minor) ____

Date of Signature ____

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

____ **(ex. Mother, Father, legal guardian....)**