



EarNoseThroat
AllergySnoring
C E N T E R

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Information:

Full Name: _____
Date of Birth: _____ | Phone Number: _____
Address: _____
City: _____ State: _____ ZIP: _____

I hereby authorize:

Franklin Douglass MD-PA ENTAS-C :

Address: _6611 FM 2920 Spring TX, 77379_____
Phone: __281-376-1188____ Fax: _____936-539-9104_____

To release my medical records to:

Name of Individual/Facility Receiving Records:

Address: _____
Phone: _____ Fax: _____

I authorize the release of my medical records to the physician or healthcare facility listed above for the purpose of continuing my medical care. I understand that this disclosure may include sensitive information. I understand that once the information is released, it may no longer be protected under federal privacy laws but will be handled in accordance with the receiving provider's confidentiality policies. This authorization is voluntary, and I may revoke it at any time in writing, except to the extent that action has already been taken in reliance on it.

Patient signature: _____

Date: _____