

**Authorization Form
For Release of Protected Health Information**

By signing this form, I authorize Frank Castillon, III, M.D., P.A. to use and disclose the protected health information described below.

Patient Name: _____ DOB: _____

Please list persons, other than yourself, that you allow us to share information with including but not limited to your medical care, appointments, test results, prescriptions and/or financial matters.

Doctors SHOULD NOT be on this list. Privacy Laws allow us to share information with your referring physician, other physicians participating in your medical care and/or facilities where we order/schedule medical tests, studies, treatments or evaluations.

1. _____ Phone# _____
2. _____ Phone# _____
3. _____ Phone# _____
4. _____ Phone# _____
5. _____ Phone# _____

If you wish for mailed correspondence to be sent to any address other than the one listed on your information sheet, you must provide and alternative address here.

Alternate Address: _____

If you wish for telephone calls to be made to any other phone number other than the one listed on your information sheet, you must provide an alternative number(s) here.

Alternate Telephone Number:

I AM FULLY AWARE THAT A CELL/MOBILE PHONE IS NOT A SECURE AND/OR PRIVATE LINE.

May confidential messages (i.e., appointment reminders, MRI results) be left on your telephone answering machine or voice mail? Y N

This authorization shall be in force and effective until you inform us otherwise.

I understand that I have a right to revoke this authorization, in writing, at any time by sending a written notification to the following person at the practice.

**Privacy Officer/Office Manager
Frank Castillon, III, M.D., P.A.
10670 N Central Expressway, Ste 200
Dallas, Texas 75231
P: 214-660-5650
F: 214-987-1120**

I understand that a revocation is not effective to the extent That the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

Signature of Patient/Representative

Printed Name of Patient/Representative

Date

Relationship of Patient/Representative