

Medical Records Release

By signing this form, I authorize Frank Castillon, III, MD, PA to request Medical Records and reports of Film Studies.

Patients Name: _____

DOB: _____

The health information requested:

Release my protected health information to the following:

Frank Castillon, III, MD, PA
10670 N. Central Expwy
Ste 200
Dallas, TX 75231
Office 214-660-5650
Fax 214-987-1120

Patients Signature: _____

Date: _____