Authorization Form
For Disclosure of Protected Health Information

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

Patient Name: _____ DOB: _____

Please list below any person that you authorize us to share information with, including but not limited to, your medical care, appointments, test results, prescriptions and/or financial matters. Most commonly, this is a family member (spouse or significant other, adult children or siblings, caregiver, etc).

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. _____Relationship:_____Phone#_____

2. _____Relationship:_____Phone#_____

3. _____Relationship:_____Phone#_____

4. _____Relationship:_____Phone#_____

5. _____Relationship:_____Phone#_____

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? **Yes No**

This authorization shall be in force and effective until you inform us otherwise. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

I understand that I have a right to revoke this authorization, in writing, at any time by providing written notification.

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