Medical Records Release

By signing this form, I authorize **Frank Castillon, III, M.D**., to request medical records and radiology reports.

Patient Name: ____

DOB: ____

The health information requested:

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Release my protected health information to the following:

Frank Castillon, III, M.D.
2424 50th Street, Suite 100
Lubbock, TX 79412
Office: (806) 761-0722
Fax: (806) 797-1265

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Signature   Date

3/15/16