JOSE GABRIEL CASTELLANOS, M.D., INC.
234 E BADILLO ST, COVINA, CA 91723
PHONE: (626)915-9992 FAX: (626)410-1121

AUTHORIZATION FOR MEDICAL RECORD RELEASE

(Please fill out this form if you would like medical records sent to our office)

Doctor's Info

TO: _____

CITY: _____ **ZIP:** _____

PHONE: _____ **FAX:** _____

Duration: **This authorization shall become effective immediately and shall remain in effect from / / 2020 or for one year from the date of signature.**

Revocation: **This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.**

Re-disclosure: **I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.**

Patient Info

PATIENT NAME: _____

DATE OF BIRTH: _____ **SOCIAL SEC. NUMBER:** _____

SIGNATURE: _____ **DATE:** _____

RELATIONSHIP (*if signed by someone other than patient*)**:** _____

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS TO JOSE GABRIEL CASTELLANOS, MD

RECORDS TO BE RELEASED:

****** Please do not send progress notes ******

- ✕ **Last 3 years of labs and radiology reports**
- ✕ **Any and all surgical reports**
- ✕ **Any and all diagnostic tests (mammogram, colonoscopies, etc.)**
- ✕ **Immunization Records**
- ✕ **Other:** _____

PREFERRED METHOD OF DELIVERY: FAX TO (626)410-1121