Personalized Hematology-Oncology of Wake Forest

11635 NorthPark Drive, Suite 250
Wake Forest, NC 27587-6298
Phone: 919.825.4637
Fax: 919.562.0444
info@wakeforest-personalized-hemonc.com
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AUTHORIZATION FOR RELEASE OF HEALTH/PATIENT INFORMATION

(Over 20 pages, please mail)

Patient Name _____ **Date of Birth** _____

The above named person must indicate when this authorization is to expire:

- ☐ When Information is Received
- ☐ In Six Months
- ☐ In One Year
- ☐ In Three Years
- ☐ On Specified Date_____

The person named above is or has been a patient of:

Personalized Hematology-Oncology of Wake Forest, PLLC
Dr. Francisco A. Castillos III, MD
11635 NorthPark Drive, Suite 250
Wake Forest, NC 27587-6298
(919) 825-4637 office
(919) 562-0444 fax

The person named above hereby authorizes Dr. Francisco A. Castillos III, MD to

- ☐ Request health/patient information from
- ☐ Discuss health/patient information with
- ☐ Send health/patient information to

From representatives of the following:

Name of Person/Provider/Facility _____
Address _____
_____
City, State, Zip Code _____
Phone _____
Fax _____

Scope:

- ☐ All information regarding assessment, diagnosis and treatment of patient's condition, concern or disease (specify):
  _____
  _____
- ☐ All information regarding care received by patient between the dates of:
  _____ and _____
  Start Date End Date
- ☐ Other information (specify):
  _____
  _____

Authorization:

_____

Printed Name of Patient or Authorized Representative

_____ _____ _____ _____

Signature of Patient or Authorized Representative **Date** **Signature of Witness** **Date**

If not signed by the patient, indicate relationship of authorizing person to patient:

- ☐ Parent or guardian of minor child
- ☐ Guardian or conservator of conserved patient
- ☐ Beneficiary or personal representative of a deceased individual