

For the office of:

Private Health MD, P.A.

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Winter Park, FL 32789
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Authorization for the Use and Disclosure of Individually Identifiable Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by Federal Privacy Regulations.

Persons/ organizations authorized to use or disclose the information:

Persons/ organizations authorized to receive the information:
Ivan J Castro MD of Private Health MD PA

Specific description of information that may be disclosed:
Progress notes, lab reports, imaging reports, immunization records, surgical reports, medical history

I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign or my revocation of this Authorization will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law.

The person/ organization authorized to use/ disclose the information will receive compensation for doing so.
Yes ___ No X

I understand that I may inspect or copy the information used or disclosed.

I understand that I may revoke this Authorization at any time by notifying the person/ organization providing the information in writing, except to the extent that:
-action has been taken in reliance on this authorization; or
-if this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with right to consent a claim under the policy.

The authorization expires on [redacted]. If I don't specify an expiration date or event, this authorization will expire in 6 months.

Printed name of Patient [redacted] Date [redacted]

Address [redacted]

Social Security Number [redacted] Date of Birth [redacted]

Signature of patient or patient's representative [redacted]

Relationship to patient or authority to act for the patient _____