WESTLAKE ORTHOPAEDICS
SPINE & SPORTS

Authorization for Release of Protected Health Information (PHI)

Patient Name: **DOB:**

Mailing Address:

Home#: **Cell#:** **SS#:**

Records Sent From:

Westlake Orthopaedics Spine and Sports
5656 Bee Caves Rd. Ste. K-200
Phone: 512-329-6644 Austin, Texas 78746
Fax: 512-891-8220

Records Sent To:

_____
_____
_____
_____

☐ Thomas Burns MD ☐ Frosty D.R. Moore MD
☐ Matthew Crawford, DO., Ph.D. ☐ Scott Spann MD

Information to be released: (Check all that apply)

☐ Progress Notes ☐ Most Recent History/Physical
☐ Lab Reports ☐ Radiology/Imaging Reports/Films
☐ Entire Medical Record ☐ Other _____

Description of the purpose of the use and or/disclosure: (Check one)

☐ Continuing Care ☐ Second opinion ☐ Consultation
☐ Emergency Care ☐ Insurance ☐ Legal Purposes
☐ Personal Use ☐ Social Security/Disability
☐ Other_____

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of any health care will not be affected if I do not sign this form. I may inspect or copy the information to be used or disclosed, and that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient, and may no longer be protected by federal and state privacy regulations. WLO may charge a processing fee for this service. This authorization will expire by law 180 days from the days from the date of this authorization unless I otherwise specify. This authorization will be in effect until _____(date or event).

I further understand that I may revoke this authorization at any time by notifying the Health Information Management Department of WLO. If I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Signature of Patient or Patient Representative: Printed Name of Patient/Patient Representative:

Date: