



Authorization for Release of Protected Health Information (PHI)

Patient Name:

DOB:

Mailing Address:

Home#:

Cell#:

Records Sent From:

Records Sent To:

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

Four horizontal lines for recipient information.

- Thomas Burns MD, Scott Spann, MD, Matthew Crawford, DO, Ph.D.

Information to be released: (Check all that apply)

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

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

- Continuing Care, Emergency Care, Personal Use, Other, Second opinion, Insurance, Social Security/Disability, Consultation, Legal Purposes

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 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.

Signature of Patient or Patient Representative:

Printed Name of Patient/Patient Representative:

Date: