Authorization for Release of Protected Health Information (PHI)

Patient Name:

Mailing Address:

Home #: **Cell #:** **SSN:**

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	______________________________

☐ Thomas Burns, M.D.

☐ Matthew Crawford, D.O., Ph.D.

☐ Scott Spann, M.D.

Previous Physicians:

☐ Grayson Moore, M.D.

☐ Frosty Moore, M.D.

Information to be released (Check all that apply):

☐ Progress Notes ☐ Lab Reports ☐ Entire Medical Record

☐ Most Recent History/Physical ☐ Radiology/Reports/Films ☐ 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 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 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: ________________________________