WESTLAKE ORTHOPAEDICS
SPINE & SPORTS

Authorization for Release of Protected Health Information (PHI)

Patient Name: **DOB:**
Mailing Address:
Phone #:

Records Sent From:

_____
_____
_____
_____

Records Sent To:

Westlake Orthopaedics Spine and Sports
P.O. Box 161390
Austin, TX 78716
Ph: 737-231-5500 Fax: 737-843-1120

☐ Scott Spann, M.D.
☐ Thomas Burns, M.D.
☐ Matthew Crawford, D.O., 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
☐Insurance
☐Legal Purposes
☐Social Security/Disability
☐ Second Opinion Consultation
☐Emergency Care
☐ Personal Use
☐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: