



Sara Westgate, M.D., Ph.D.
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**AUTHORIZATION FOR RELEASE OF
PROTECTED HEALTH INFORMATION**

USE THIS AS YOUR FAX COVERSHEET

Patient: _____ **D.O.B.:** _____ **Last 4 of SS#:** _____

I hereby authorize:

Physician/Facility/Person Phone

Address Fax

To release my Protected Health Information (PHI) to: Sara Westgate, M.D., Ph.D.
5900 Southwest Parkway
Building IV, Suite 401
Austin, TX 78735-6206
fax (512) 458-1035

PHI to be disclosed:

- History & Physical Initial Consultation
- Laboratory Radiology studies
- Immunizations Progress Notes
- Other: _____

(Please specify as necessary: example: MRI of brain , B12 level, TSH, Ultrasound, or All next to section)

Inclusive dates of treatment from: _____ **to:** _____

Purpose for release of information:

- "at the request of the individual"
- Other: _____

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Reports may include information on drug/alcohol abuse, psychological/psychiatric diagnoses, and communicable diseases including HIV. Austin NeuroCare will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

I understand that I may revoke this consent anytime except to the extent that action has already been taken before receipt of such revocation. This authorization expires automatically one hundred eighty (180) days from the date of signatures or earlier if otherwise specified. I understand that I may be charged for copies of my medical records. I understand that these records are protected under federal and state laws and cannot be disclosed without my consent except when required by law. I understand that the organization releasing my records will not be responsible for dissemination or disclosure of my confidential medical information when this clinic provides such information, at my request, to my health insurer, employer, attorney or other designee.

Signature of Patient or Patient's Representative Date

(Description of Patient's Representative i.e. Power of Attorney, Legal Guardian, Executor/Administrator)

Sara Westgate, M.D. Ph.D.

Cheri Maney, FNP