Sara Westgate, M.D., Ph.D.
5900 Southwest Parkway, Building IV, Suite 401
Austin, TX 78735-6206
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(p) 512-458-6656 (f) 512-458-1035

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

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

I hereby authorize:

Sara Westgate, M.D., Ph.D.
5900 Southwest Parkway
Building IV, Suite 401
Austin, TX 78735-6206

To release my Protected Health Information (PHI) to: _____
Physician/Facility/Person

_____
Mailing address/phone/fax

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:** _____
(Please complete the above dates of service section)

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.

_____ Date_____
Signature of Patient or Patient's Representative

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

Sara Westgate, M.D. Ph.D. *Cheri Maney, FNP*