WESTLAKE
DERMATOLOGY
& Cosmetic Surgery

PMS ID

Authorization for Use and Disclosure of Protected Health Information to a Spouse or Other Individual

This form authorizes Westlake Dermatology and its designated representatives to use and disclose your Protected Health Information ("PHI") to your spouse or other individual described below, for a purpose other than treatment, payment, or health care operations and at your request. You only need to complete this Authorization if you want Westlake Dermatology to disclose your PHI to your spouse or another individual to whom you authorize us to disclose your PHI. PHI is information that identifies you as a Westlake Dermatology patient and relates to your past, present, or future physical or mental health condition and related health services.

Patient Name: _____ DOB: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Individuals Authorized to Receive PHI from Westlake Dermatology

Name of Person to Receive PHI	Relationship to Patient	Address	Telephone Number	Duration of Authorization

☐ I authorize Westlake Dermatology to release my entire medical and billing records. I understand that checking this box authorizes the use or disclosure of all information in my medical and billing record including, demographic information, pathology results, imaging reports, laboratory reports, prescription history, and other sensitive information.

☐ I authorize Westlake Dermatology to release only the following information from my medical and billing records:

_____

☐ I authorize this information to be disclosed electronically, if requested.

I understand that I may refuse to sign this Authorization. I also understand that information released to the person(s) authorized above may be subject to re-disclosure by the recipient and may no longer be protected by Federal and state privacy regulations. This Authorization shall remain effective indefinitely, unless otherwise stated above or revoked by me by providing written notice to Westlake Dermatology addressed to the: ***Privacy Officer****, 8825 Bee Caves Road, Austin, Texas, 78746. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information.*

Please send completed form to your provider using the secure link on our website or fax to (512) 615-3184.

_____ _____

Signature of Patient Date