

**John E. West, M.D., P.C.**  
**Authorization for Use/Release of Health Information**

By signing this form, I authorize John E. West, M.D., P.C. to use, release or disclose the protected health information described below to:

Person/Organization: \_\_\_\_\_  
\_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

This authorization expires upon fulfillment of request unless noted with expiration date. \_\_\_\_\_  
Exp. Date

I authorize the following information to be sent to the address above:

\_\_\_\_\_ Copies of all medical records for the period \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_ Copies of medical records pertaining to: \_\_\_\_\_

Period from \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_ History/Physical Exam \_\_\_\_\_ Lab/X-ray \_\_\_\_\_ Other

I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV); behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.

The following information should not be released, even if occurring during dates above:

\_\_\_\_\_

I have been provided a copy of John E. West, M.D., P.C.'s *Notice of Privacy Practices* and any charges that may be associated with this authorization. I have discussed any concerns I may have about the use, release, disclosure of my health information with John E. West, M.D., P.C.'s Privacy Officer or other appropriate office personnel. I understand that John E. West, M.D., P.C. assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release John E. West, M.D., P.C. from all legal liability that may arise from this authorization.

Patient's Name (please print) \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

SS# \_\_\_\_\_ DOB \_\_\_\_\_

If the signature above is not that of the patient, I am acting for the patient because \_\_\_\_\_

My relationship to the patient is: \_\_\_\_\_ Signed \_\_\_\_\_

The patient or their representative may revoke this authorization by notifying in writing John E. West, M.D., P.C.'s designated Privacy Officer. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule. Federal Law also requires a statement that there is the potential for the protected health information released under this authorization to be subject to re-disclosure by the recipient.