RACHEL WEST, D.O.
CONTEMPORARY MEDICINE

12300 WILSHIRE BLVD., SUITE 420 • LOS ANGELES, CA 90025
TEL: (310) 450-8959 • FAX (310) 450-8342 - WWW.DRRACHELWEST.COM

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

WE CANNOT SHARE ANY OF YOUR MEDICAL INFORMATION WITH A SPOUSE/PARENT/CHILD/FRIEND WITHOUT YOUR AUTHORIZATION

PLEASE FILL OUT THIS FORM IF YOU WANT TO GIVE US THE ABILITY TO COMMUNICATE ABOUT YOUR CARE WITH A SPOUSE/PARENT/ CARE COORDINATOR/FRIEND.

RECIPIENT:

I voluntarily consent to authorize Dr. Rachel West (my health care provider) to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

I authorize my health care information to be released to the following recipient(s):

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

INFORMATION TO BE DISCLOSED:

I authorize the release of the following health information: (check the applicable box below)

☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, physical condition, and any treatment received by me.

☐ Only the following records or types of health information:

_____

Terms:

This Authorization will remain in effect:

☐ From the date of this Authorization until _____

_____ _____ _____

Signature Date Signature of Witness

If Individual is unable to sign this Authorization, please complete the information below:

_____ _____ _____

Name of Guardian Date Signature of Witness