Bruce S. West, MD ~ Raeann Alboher, ARNP ~ Amelia. B. Phillips, ARNP
1340 S 18th St, Ste 203 ~ Fernandina Beach, FL 32034
Telephone (904) 261-7707 ~ Facsimile (904) 261-8616

Release Records ____To: ____From:
Physician/Facility:
Address:
City/State/ZIP
Phone: FAX:

Records pertaining to name(s)/date(s) of birth:
1
2
3

Records being released (please indicate):

- ___Entire record
- ___History and Physical
- ___Consultation Records
- ___Discharge Summary
- ___Emergency Department Records
- ___Laboratory Reports
- ___Pathology Reports
- ___Radiology Reports
- ___Operative Reports
- ___Immunization Records

Dates of Service: ___ All ___ Last visit only ___ From __________ To __________

Purpose of release: ____

- I hereby authorize, per the above instructions, the release/receipt of protected health information. I am aware that such records may contain information related to mental health, substance abuse, and sexually transmitted diseases (including HIV) and I specifically authorize the release of such information pursuant to the above instructions.
- I understand that this authorization will remain in effect for one year, but I may revoke it at any time in writing. I understand that any such revocation will not apply to records already released. I understand that I am under no obligation to sign this authorization, and that treatment by either of the above entities does not require this authorization. I may receive a copy of this document.
- I understand that State and federal law may prohibit the recipient from re-disclosing information provided pursuant to this authorization, but that neither Dr. West nor the above- referenced entity(s) has any control over the recipient and cannot, therefore, guarantee that the recipient will not re-disclose such information. I hereby release Dr. West and the above-referenced entity(s) from any and all liability related to (i) reliance upon this Authorization or (ii) the release of information pursuant to this Authorization.
- By signing below, I authorize the above-referenced entity(s) to release medical information about me as described above.

____ ____________________________
Signature of Patient Date Time

If the patient is (i) a minor, then the patient's parent or guardian should consent by signing below; or (ii) an adult but mentally or physically unable to consent for himself or herself, then the patient's guardian, legal representative, attorney-in-fact, surrogate or proxy should consent on the patient's behalf by signing below:

____ ____________________________
Signature of Representative Date Time Telephone number

____ ____________________________
Name of Representative Relationship to Patient