Robert M. West, D.O.
2315 Dougherty Ferry Rd Ste 107
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(314) 966-7570

Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I have been provided with a Notice of Privacy Practices, effective Sept. 23, 2013, that provides a more complete description of my health information uses and disclosures. This Notice replaces the previous Notice of 2003. I understand that I have the right to review the notice prior to signing this consent. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations. I understand that the refusal to sign this consent or my request for restrictions will not affect my treatment however I may be personally responsible for payment of services.

I request the following restrictions and/or additional permissions of the use of my health information. (e.g. family members we have your permission to speak with regarding your care):_____
_____
_____
_____
_____
_____

This authorization will remain valid unless changed by me in writing to Robert M. West, D.O.

_____ _____
Patient Name (Print) Date

_____ _____
Patient Signature Witness