Ada West Dermatology
1618 S. Millennium Way, Suite 100
Meridian, ID 83642
Phone: (208) 884-3376
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RELEASE OF MEDICAL RECORDS
FROM
ADA WEST DERMATOLOGY

Patient Name (First Middle Last): _____

Birth Date: _____ **Last Four Digits of SSN** _____

Records requested:

☐ All pathology/labs/visit notes

☐ Pathology

☐ Labs

☐ Visit notes Date Range from _____ to _____

Purpose/need for records:_____

_____ _____
Signature Date

I herby authorize Ada West Dermatology to release any and all information relating to my medical treatment. This form validates release of all medical records including clinical notes, operative reports, pathology reports, and diagnostic studies to the following undersigned party:

To: _____

_____

_____

Phone: _____ Fax: _____

This authorization is valid for one year from today's date unless revoked in writing.

This authorization may be revoked in writing at any time with the exception of information released prior to the date of the written revocation. I understand that once Ada West Dermatology discloses my health information to the recipient, Ada West Dermatology cannot guarantee that the recipient will not re-disclose my health information to a third party.

FOR OFFICE USE ONLY

Date mailed/faxed_____ by (initials)_____

Date delivered to patient_____ by (initials)_____