Ada West Dermatology
1618 S. Millennium Way, Suite 100
Meridian, ID 83642
Phone: (208) 884-3376
Fax: (208) 884-0858

RELEASE OF MEDICAL RECORDS FROM ADA WEST DERMATOLOGY

Patient Name: _____

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

Purpose/Need for Records:

☐ Personal
☐ Insurance
☐ Legal
☐ Treatment/Continuation of Care
☐ Workers Compensation
☐ School
☐ Other: _____

Records to be Released:

☐ All Pathology / Labs / Imaging / Visit Notes
☐ Pathology
☐ Labs
☐ Imaging
☐ Visit Notes Dates of Service: from: _____ to: _____

I hereby authorize Ada West Dermatology to release the information indicated above to the following party:

To: _____
_____
_____
Phone: _____
Fax: _____

If releasing records to yourself, please indicate how you would like to receive your records:

☐ Pick Up at Clinic (call when ready)
☐ Mail Records
☐ Fax Records

(1) I may revoke this authorization at any time by providing written notice to Ada West Dermatology, except to the extent that action has already been taken based on this authorization.
(2) I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Privacy Regulations.
(3) This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

This authorization will expire one (1) year from date signed.

Signature: _____ Date: _____

FOR OFFICE USE ONLY

Date mailed/faxed: _____ by (initials): _____

Date delivered to patient: _____ by (initials): _____