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 (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 _____

_____ _____
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:

Requesting Facility: _____

_____

_____

Phone: _____ Fax: _____

FOR OFFICE USE ONLY

Date mailed/faxed_____ by (initials)_____

Date delivered to patient_____ by (initials)_____