

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 _____

Purpose/need for records: _____

Signature

Date

I hereby 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) _____

THIS MESSAGE IS INTENDED ONLY FOR THE PERSON OR OFFICE IT IS ADDRESSED AND MAY CONTAIN INFORMATION THAT IS PRIVILEGED, CONFIDENTIAL OR PROTECTED BY LAW. ALL OTHERS ARE HEREBY NOTIFIED THAT RECEIPT OF THIS MESSAGE DOES NOT WAIVE ANY APPLICABLE PRIVILEGE OR EXEMPTION FROM DISCLOSURE AND THAT DISSEMINATION, DISTRIBUTION, OR COPYING OF THIS COMMUNICATION IS PROHIBITED. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE NOTIFY US IMMEDIATELY AT 208-884-3376 AND RETURN THE MESSAGE TO ADA WEST DERMATOLOGY VIA THE UNITED STATES POSTAL SERVICE. THANK YOU.