

**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:**

- |   |   |
|---|---|
| <input type="checkbox"/> Personal                       | <input type="checkbox"/> Workers Compensation |
| <input type="checkbox"/> Insurance                      | <input type="checkbox"/> School               |
| <input type="checkbox"/> Legal                          | <input type="checkbox"/> Other: _____         |
| <input type="checkbox"/> Treatment/Continuation of Care |   |

**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): \_\_\_\_\_

THIS DOCUMENT 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 DOCUMENT DOES NOT WAIVE ANY APPLICABLE PRIVILEGE OR EXEMPTION FROM DISCLOSURE AND THAT DESSEMINATION, DISTRIBUTION, OR COPYING OF THIS DOCUMENT IS PROHIBITED. IF YOU HAVE RECEIVED THIS DOCUMENT IN ERROR, PLEASE NOTIFY US IMMEDIATELY AT 208-884-3376 AND RETURN THE DOCUMENT TO ADA WEST DERMATOLOGY VIA THE UNITED STATES POSTAL SERVICE. THANK YOU.