

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

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