

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: _____ **Social Security #:** _____

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 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 DESSEMINATION, 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.