

Ada West Dermatology
1618 S. Millennium Way, Suite 100
Meridian, ID 83642
Phone: (208) 884-3376
Fax: (208) 884-0858

REQUEST FOR MEDICAL RECORDS FROM:

_____ Phone: _____
_____ Fax: _____

Records requested:

- All pathology/labs/visit notes
- Pathology
- Labs
- Visit notes Date Range from _____ to _____

Purpose/need for records: _____

I hereby authorize you to release any and all information relating to my medical treatment while under your care. This form validates release of all medical records including clinical notes, operative reports, pathology reports, and diagnostic studies. Please forward such documents to the following address:

ADA WEST DERMATOLOGY
1618 S. Millennium Way, Suite 100
Meridian, ID 83642
Phone (208) 884-3376 Fax (208)884-0858

This authorization is valid for one year from today's date unless revoked in writing.

Patient Name (First Middle Last): _____

Birth Date: _____ **Last Four Digits of SSN** _____

Signature

Date

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 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.