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)_____