

Main Clinic  
1618 S Millennium Way Ste 100  
Meridian ID 83642  
(208) 884-3376



Ten Mile Clinic  
4574 N Ten Mile Rd Ste 120  
Meridian ID 83646  
(208) 884-3376

**RELEASE OF MEDICAL RECORDS FROM ADA WEST DERMATOLOGY**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Last Four Digits of SSN: \_\_\_\_\_

**Purpose/Need for Records:**

- Personal
- Insurance
- Legal
- Treatment/Continuation of Care
- Workers Compensation
- School
- Other: \_\_\_\_\_

**Records to be Released:**

- All Pathology/Labs/Imaging / Visit Notes
- Pathology
- Labs
- Imaging
- Visit Notes Dates of Service from: \_\_\_\_\_ to: \_\_\_\_\_

**I authorize Ada West Dermatology to release the information indicated above to the following party:**

To: \_\_\_\_\_  
\_\_\_\_\_

If releasing records to yourself, please indicate how you would like to receive your records:

Phone: \_\_\_\_\_

Pick Up at Clinic (we will call when ready)

Fax: \_\_\_\_\_

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: \_\_\_\_\_

<p><b>FOR OFFICE USE ONLY</b></p> <p>Date mailed/faxed: _____ by (initials): _____</p> <p>Date delivered to patient: _____ by (initials): _____</p>
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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.