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

Ada West
DERMATOLOGY

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

REQUEST FOR MEDICAL RECORDS TO 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 Requested:

☐ All Pathology/Labs/Imaging/Visit Notes
☐ Pathology
☐ Labs
☐ Imaging
☐ Visit Notes Dates of Service: from: _____________ to: _____________

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

From: ____________________________________
____
____
Phone: ________________________________
Fax: ________________________________

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

(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**: _____________________

FOR OFFICE USE ONLY

Date mailed/faxed: ______________________________ by (initials): _________________________

Date delivered to patient: __________________________ by (initials): _________________________

THIS DOCUMENT IS INTENDED ONLY FOR THE PERSON OR OFFICE IT IS ADDRESSED AND MAY CONTAIN INFORMATION THAT IS PRIVILEDGED, CONFIDENTIAL OR PROTECTED BY LAW. ALL OTHERS ARE HEREBY NOTIFIED THAT RECEIPT OF THIS DOCUMENT DOES NOT WAIVE ANY APPLICABLE PRIVILEDGE OR EXEMPTION FROM DISCLOSURE AND THAT DESSEMINATION, DISTRIBUTION, OR COPYING OF THIS COMMUNICATION 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.