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

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name:_____ **Date of Birth:** _____

I hereby authorize Ada West Dermatology to disclose the specific information described below only for the purpose(s) and to the individual(s) also described below.

Description of the specific information to be disclosed:

□ Appointment Information
□ Visit or Progress Notes
□ Lab Tests/Results
□ Imaging Results
□ Diagnosis/Care Plan
□ Medications
□ Billing
□ Other _____
□ Any and All Information

Confidential Information to be disclosed: *(please note this information will not be released if not checked)*

□ Mental Health Information
□ HIV Information
□ Alcohol/Drug Information
□ Genetic Testing Information

Purpose(s) for this authorization is (check all that apply):

□ Individual's Request
□ Medical Care
□ Other: _____

Recipient(s) of information:

Name	Date of Birth	Relationship	Phone Number

This authorization shall remain in effect one year from the date signed or:

□ Five (5) years from date signed

I acknowledge and understand that:

- This authorization is giving Ada West Dermatology the right to disclose my medical information to the individual(s) listed above.
- I may inspect and/or receive a copy of the information described on this authorization by completing this form and signing below.
- I have the right to 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.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA Privacy Regulations.
- This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

Signature of Patient **or** Representative: _____ Date: _____

Representative Name (printed): _____ Authority: _____
(If signed by the patient's Personal Representative, please print name and describe authority to act for the individual.)