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

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:

❖ Please Note: Form must include a phone number **and** fax number of where records are being released. If a fax number is not available please at minimum provide a phone number. Forms that are left blank will be shredded. Thank you.

To:_______________________________________
____
____
Phone:____________________________________
Fax: ______________________________________

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

☐ Pick Up at Clinic (we will call when ready)
☐ 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**:_________________________

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 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.