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:

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

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): _____