

RELEASE OF MEDICAL RECORDS FROM ADA WEST DERMATOLOGY

Patient Legal 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: _____

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:** _____

FOR OFFICE USE ONLY	
Date mailed/faxed: _____	by (initials): _____
Date delivered to patient: _____	by (initials): _____