

Ada West DERMATOLOGY

RELEASE OF MEDICAL RECORDS FROM ADA WEST DERMATOLOGY

Patient Name: _____ Date of Birth: _____

Purpose/Need for Records:

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Personal | <input type="checkbox"/> Treatment/Continuation of Care |
| <input type="checkbox"/> Insurance | <input type="checkbox"/> Workers Compensation |
| <input type="checkbox"/> Legal | <input type="checkbox"/> School |
| <input type="checkbox"/> Other: _____ | |

Records Releasing:

- | | |
|--|---|
| <input type="checkbox"/> Records pertaining to Skin Cancer | <input type="checkbox"/> Records with this diagnosis: _____ |
| <input type="checkbox"/> Imaging | <input type="checkbox"/> Labs |
| <input type="checkbox"/> Pathology | <input type="checkbox"/> All Pathology/Labs/Imaging/Visit Notes |
| <input type="checkbox"/> Visit Notes with dates of service from: _____ to: _____ | |

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

To: _____

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

Phone: _____

Fax: _____

(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 PRIVILEGED, CONFIDENTIAL OR PROTECTED BY LAW. ALL OTHERS ARE HEREBY NOTIFIED THAT RECEIPT OF THIS DOCUMENT DOES NOT WAIVE ANY APPLICABLE PRIVILEGE 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.