Ada West
DERMATOLOGY
Diseases of the Skin, Hair, Nails, & Skin Cancer Treatment

REQUEST FOR MEDICAL RECORDS TO ADA WEST DERMATOLOGY

Patient Name:	**Date of Birth:**

Purpose/Need for Records:

☐ Personal
☐ Insurance
☐ Legal
☐ Other: _____
☐ Treatment/Continuation of Care
☐ Workers Compensation
☐ School

Records Requesting:

☐ Records pertaining to Skin Cancer
☐ Imaging
☐ Pathology
☐ Visit Notes with dates of service from: _____ to: _____
☐ Records with this diagnosis: _____
☐ Labs
☐ All Pathology/Labs/Imaging/Visit Notes

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

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 expires one (1) year from the date signed.**

Signature: _____ Date: _____

FOR OFFICE USE ONLY

Date mailed/faxed: _____ by (initials): _____

Date delivered to patient: _____ by (initials): _____