



DERMATOLOGY CLINIC OF IDAHO

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DIPLOMATE AMERICAN BOARD OF DERMATOLOGY
FELLOW AMERICAN ACADEMY OF DERMATOLOGY
FELLOW AMERICAN SOCIETY FOR MOHS SURGERY

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MEDICAL RECORDS REQUEST

Dear _____

Address: _____

Phone: _____ Fax: _____

RECORDS RELEASE AUTHORIZATION FOR:

Patient Name: _____

Date of birth: _____

Address: _____

I Hereby Authorize you to release to:

Provider/Facility: _____

Address: _____

Phone: _____ Fax: _____

Personal request:

Patient medical records:

Lab Reports:

I hereby consent to the release of specified medical information relating to diagnosis, testing or treatment to the entity named above. I understand that such information cannot be released without my informed consent, with the exception of doctor to doctor transmission and insurance transmission. My signature below indicates I agree to and authorize the release of patient health information and I have the right to revoke or cancel this authorization at any time.

Patient Signature _____ Date _____