



DERMATOLOGY CLINIC OF IDAHO

7733 W Emerald St – Boise, ID 83704
Phone: (208)939-4599 Fax: (208)939-5010

James H. Stewart, PH.D., M.D.
Michael Housley, PA-C
Tyler McKinnon, PA-C
Chelsea Wood, PA-C

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:

Records from Date: _____ To Date: _____

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 and/or in accordance with Federal and State law. 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 _____