DERMATOLOGY CLINIC OF IDAHO

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MEDICAL RECORDS REQUEST

Provider/Facility : _____

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_____