North Idaho DERMATOLOGY

2288 N. Merritt Creek Loop
Coeur d'Alene, ID 83814

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niderm.com

***** Some requests may be subject to a $10.00 charge with 10 cents per page for copying complete records*****

Please Initial That You Have Read The Above Charges_____

AUTHORIZATION TO RELEASE/REQUEST MEDICAL INFORMATION

Patient Name: _____

Birth Date: _____ Social Security#: _____ Phone: _____

I authorize North Idaho Dermatology – 2288 N. Merritt Creek Loop – CDA, ID 83814 to *(CIRCLE ONE) release*/**request** my (medical), (dermatological), and/or (lab) records *to*/**from**:

_____ FAX
(NAME/OFFICE)

OR

_____
(ADDRESS) MAIL

_____ / _____ $_____
(PHONE #) **/ (FAX #)**

Please Check All That Apply:

( ) All Medical Records (or specify Dates):_____

( ) All Dermatological (or specify Dates):_____

( ) All Laboratory, Pathology (or specify Dates):_____

( ) Other (s): _____

READ THE FOLLOWING CAREFULLY:

I understand that my express consent is required for the Supplier to release information relating to a sexually transmitted disease, mental illness, psychiatric treatment, and/or alcohol abuse, and/or medical records relating to such diagnosis, testing or treatment. I understand that the Supplier cannot limit or control the subsequent use of dissemination of medical information by the party to whom I request the information be furnished. This request is a free and voluntary act by me. I hereby release the Supplier and its staff from all legal responsibility that may arise from the release of the medical information hereby authorized. A photocopy of the Authorization may be used for all purposes as an original. **Please allow 7-10 business days for processing**.

_____ _____
Patient's/Legal Guardian's Signature Today's Date