



Brock Andersen, MD, FAAD
Thad Wilkey, PA-C
Hailey Alexander, PA-C
Téa Hasanovic, PA-C

Snake River Dermatology
Phone (208) 452 5999
Fax (208) 452 4499
snakeriverderm@fmtc.com

AUTHORIZATION TO RELEASE MEDIAL RECORD INFORMATION

Patient Name: _____ DOB: _____

Address: _____ Phone: _____

To: _____ Phone: _____

Address: _____ Fax: _____

From: _____ Phone: _____

Address: _____ Fax: _____

Purpose for records: _____

Copies that need to be released: (Check all that apply)

Labs

Pathology

Procedure Notes

Other: _____

*This authorization is valid for one year from today's date unless revoked in writing.

This authorization may be revoked in writing at any time with the exception of information released prior to the date of the written revocation. Snake River Dermatology cannot condition treatment or eligibility of benefits on whether 'the authorization' is signed. Protected health information, once released, has the potential to be redisclosed by the recipient and is no longer protected by Snake River Dermatology.

Signature: _____ Date: _____

Witnessed: _____ Date: _____