IDAHO SKIN SURGERY CENTER

1906 S. Vista Ave, Boise, ID 83705
208.433.1114 **Phone**
208.433.1115 **Fax**

975 NW 16th St, Fruitland, ID 83619
208.452.7450 **Phone**
208.452.7550 **Fax**

idahoskinsurgerycenter.com

Jared Scott, MD
Jessie Zimmerman, PA-C
Katelyn Wade, PA-C
Logan Hawker, PA-C
Brittney Irons, FNP-C

Authorization to Release Protected Health Information

Patient Name: _____ **Date of Birth:** _____

I authorize ("the Clinic") to use or disclose Protected Health Information ("PHI") contained in my medical records in the following manner:

From: _____
Physician/Institution requesting data

_____
Street Address

_____
City State Zip Phone Fax

To: _____
Physician/Institution requesting data

_____
Street Address

_____
City State Zip Phone Fax

Purpose of Release

( ) Treatment/Continued Care
( ) Application for Insurance
( ) Legal Purposes
( ) Personal
( ) Disability Determination
( ) Payment of Insurance Claim
( ) Other _____

Information to be Released

( ) All of my health information
( ) Progress Note(s)
( ) Mole mapping/photography
( ) Laboratory Report(s)
( ) Pathology Report(s)
( ) Other _____

( ) I would like a copy of my protected Health Information. I understand that a copy of my records will be made available for pickup within 30 days after the date of receipt of the request and there will be a flat fee of $6.50. If my records are mailed, postage will be additional.

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on authorization. Unless otherwise revoked, this authorization will expire 90 days from the date the authorization was signed. The facility, its employees, officers and physicians are hereby released from legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

SPECIFIC AUTHORIZATION: I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have signed here: _____

Signed: _____ Date: _____

Printed Name of Person Signing (If Not Patient) _____

Witness: _____ Date: _____

Revised on 06/19/2025