PORTLAND DERMATOLOGY CLINIC LLP

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Records Release Request

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

☐ Send to / ☐ Obtain from: _____ Date: _____
Phone: _____ Fax: _____
Street Address: _____
City/State: _____ Zip Code: _____

Information to be released:
☐ CHART NOTES (dates from/to: _____)
☐ LABS (dates from/to: _____)
☐ PATHOLOGY REPORT (dates from/to: _____)

Purpose of Disclosure:
☐ Referral/patient request/other: _____
☐ Mental Health Information ____ patient initials
☐ Genetic Testing Information ____ patient initials

Other comments: _____
_____

Please call 503-223-3104 if you have any questions. We appreciate your assistance.

This authorization may be revoked at any time. Unless revoked earlier, this consent will expire 180 days from the date of signature or shall remain in effect for the period needed to complete the request. Please allow 7-10 business days for processing.