NW DERMATOLOGY
INSTITUTE

Date: ____________________

I hereby authorize: ____

To release the following medical records to:

Northwest Dermatology Institute
2525 NW Lovejoy St, Ste 400
Portland, OR 97210

___Janet L. Roberts, MD ___Nisha S. Desai, MD ___Bert G. Tavelli, MD

___Kerianne McKeon, PA-C ___Eileen McNulty, PA-C ___Sheryl Horwitz, NP

___Recent labs____

___All Medical Records

___Pathology report(s)

___Other____

Patient Name: ______________________ ______________________________ ___________
Last First MI

Date of Birth: __________________
DD/MM/YYYY

____
Patient Signature

_______________________________________ ____________________________________
Signature of other designated person (as patient is unable to sign) Relationship to patient

Record Release Expires On (Optional): __________________

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