NORTHWEST
Dermatology & Laser Clinic
Bert G. Tavelli, M.D.
Physician & Surgeon
Dermatology & Dermatologic Surgery

AUTHORIZATION TO RELEASE MEDICAL RECORDS

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

Address:_____
Street City State Zip Code

Patient's Home Phone:_____ **Work Phone:**_____

Social Security # _____

I authorize medical information to be released

From:_____ **To:** **Bert G. Tavelli, M.D.**
Physician/Clinic

1130 NW 22nd Ave. Ste 330

_____
Street Address

Portland, OR 97210

_____ **FAX: 503-295-3065**
City/State/Zip Code **Phone: 503-295-2366**

ADDRESS MUST BE COMPLETE TO ENSURE PROMPT RESPONSE

The following information is to be released:

- ☐ All dermatologic records excluding records from outside facilities.
- ☐ All dermatologic records pertaining to the following treatment and/or dates:

_____

X _____ _____
Signature of Patient of Legally Responsible Party Relationship to Patient

X _____
Date

My medical information may (☐may not) be faxed. I understand there is a risk in faxing records and confidentiality cannot be guaranteed.
This release is effective for one year from the date it is signed unless otherwise specified.