LAKE OSWEGO DERMATOLOGY GROUP

Andrew E. Pitt, M.D. Helen Liu, M.D.
Bridget D. Hartman, M.D. Betty S. Jiang, M.D.

Patient Name:_____ Patient Date of Birth:_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION FROM:

____Lake Oswego Dermatology Group
17704 Jean Way, Suite 102
Lake Oswego, OR 97035
Phone: (503) 635-9221
Fax: (503) 635-5902

____Physician Name:_____
Address:_____
_____
Phone:_____
Fax:_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO:

____Lake Oswego Dermatology Group
17704 Jean Way, Suite 102
Lake Oswego, OR 97035
Phone: (503) 635-9221
Fax: (503) 635-5902

____Physician Name:_____
Address:_____
_____
Phone:_____
Fax:_____

This information will be used on my behalf for the following purpose:_____

I authorize the release of the last five years of medical records, if such records exist:

____Clinician chart notes
____Laboratory reports
____Pathology reports
____Other:_____

You may revoke this authorization in writing at any time except to the extent that our office has already acted on this authorization. To do so, submit a written request to the office stating that you are revoking this authorization. Unless revoked, this authorization will expire 90 days from the date of signing.

I have reviewed and I understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to a re-disclosure by the recipient and no longer protected under federal law.

_____ _____ _____
(Signature) (Relationship to patient) (Date)