AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

This authorization must be written, dated and signed by the patient or by a person authorized by law to give this authorization.

I authorize _____ to release a copy of the medical information for
(NAME OF HOSPITAL/HEALTH CARE PROVIDER)

_____ with the Date of Birth of _____/_____/_____ to:
(NAME OF PATIENT)

Northeast Oregon Surgical Clinic, LLC
Dr. Andrew Bower
2474 SW Perkins Ave
Pendleton, OR 97801
Phone: 541-966-1001
Fax: 541-966-1195
Or send via secure/encrypted email to: admin@surgeonbower.com
Or as "Direct Mail" to: ANDREW.BOWER@NEOSC.DIRECTBYGREENWAY.COM

These records are within the approx year(s) of _____, at which time I had

_____performed.
Please fax any and all of the following which are contained within my chart:

- ☐ Operative Report
- ☐ Pathology Report
- ☐ Laboratory Report
- ☐ Diagnostic Imaging Report
- ☐ Entire Chart
- ☐ Discharge Summary

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire one year from the date of signing.

_____ _____
(SIGNATURE OF PATIENT OR PERSON AUTHORIZED BY LAW) (DATE)

_____

(SIGNATURE OF WITNESS)