
**Jefferson Neurology** LLC

Bear Creek Medical Plaza
1801 Hwy 99 N
Ashland, OR 97520

Ph: 541.482.5515
Fx: 541.482.2433
www.JeffersonNeurology.com


## Patient Information

_____ _____ □ S □ M □ W □ D □ Sep

Patient's Name (Please print) S.S. # Marital Status:

□ Male □ Female _____ _____

Sex: Date of Birth Email

_____

Complete Mailing Address

_____

Complete Residential Address (If different from above)

_____ _____ _____

Home Phone Cell Phone Bus. Phone

_____ _____

Patient's or Parent's Employer Occupation

_____ _____ _____

Spouse or Parent's Name Occupation Phone

_____ _____ _____

Primary Insurance & Primary insurance holder's Date of Birth ID# Group#

_____ _____ _____

Secondary Insurance & Secondary ins. holder's Date of Birth ID# Group#

I have received and reviewed, agree and consent to the sections relating to Office Policies, Consent, Financial policies and Insurance authorization that have been provided to me.

_____

Name Signature Date

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# Family/Friends Release of Information Authorization Form

**Patient Name**: _____ **Patient DOB**: _____

I authorize Jefferson Neurology LLC to discuss ANY information regarding my care with below-mentioned persons: (Only list names of persons you are authorizing us to discuss ANY information with.)

**Name**: _____ **Relationship** _____

**Phone Number**: _____

**Name**: _____ **Relationship** _____

**Phone Number**: _____

**Others**: _____

This Authorization is valid until _____ or until revoked by the patient in writing.
If no date is listed, this authorization will expire one year from the date it was signed.

_____ _____
Patient or Legal Representative Signature Date

_____
Print Name/Relationship to Patient

You have the right to revoke this Authorization at any time, provided that you do so in writing. If you revoke you Authorization, we will no longer use or disclose information about you for the reasons coved by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. The information used to disclose pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law. Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization.

*In the event this Authorizations is signed by a legal representative other than parents of a minor child, documentation of legal authority must be attached. (i.e. Health Care Power of Attorney, or Court appointed Health Care Representative.)

*(Ver 1.5)*