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

Patient's Name (Please print) _____ S.S. # _____ Marital Status: □ S □ M □ W □ D □ Sep

Sex: □ Male □ Female 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 reviewed, agree and consent to the sections relating to policies, consent and 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 1.4)