

Permission for Verbal Communications

Jasper Neurological Associates

(Print name of patient here)

(Birth Date)

(Street address)

(City, State, zip code)

(Home Phone Number)

(Cell Phone Number)

I permit Jasper Neurological Associates, their physician, nurses, and other personnel (“Health Care Providers”) to discuss health information, in person or by telephone, with the following family members or friends involved in my medical care: (List family members/friends and state the person’s relationship to the patient).

(If no limitations are listed, discussions will be permitted regarding any medical condition for which the patient has received care).

| Name | Phone Number | Relationship |
|-------------|---------------------|---------------------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |

Release of information under this document is limited to verbal discussions with my Health Care Providers. This document does not permit release of any written health information to the individuals named above.

This authorization is limited to the following time frame from _____ (date) to _____ (date)

If, at any time, I do not want verbal discussions to be permitted between my Health Care Providers and any of the individuals named above, I must notify my Health Care Provider by contacting the Medical Records Department at Jasper Neurological Associates.

Patient’s Signature: _____

Date: _____

If this release is signed by a representative on behalf of the patient, complete the following:

Representative’s Name: _____

Relationship to Patient: _____