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:_____