Health and Medical Information Release Form

I, _____, give permission to Dr. Thomas P. Jeffers, his staff, associates, and employees of Jeffers Neck & Back Pain Center to share private and medical information with my medical doctor, _____, as well as his or her staff, employees, and associates. Also, my medical doctor, as well as his or her staff, employees, and associates have permission to share personal and medical information with Dr. Jeffers and his staff.

Signature:_____ _____Date:_____

Patient Info

Name:_____ _____

Address:_____ _____

City, State, Zip_____ _____

Phone:_____ _____ Date of Birth:_____

Medical Doctor Info

Name of Doctor:_____ _____

Address:_____ _____

City, State, Zip_____ _____

Phone:_____ _____