415 Morris Street, Suite 400
General Medical Pavilion
Charleston, WV 25301
Telephone: (304) 344-3551
Medical Fax: (304) 343-0979
www.wvneuro.com

PHYSICIANS
Lana D. Christiano, M.D.
R. Joseph Crow, Jr., M.D.
John R. Orphanos, M.D.
C. Ted Shuff, M.D.
John H. Schmidt, III, M.D., F.A.C.S.
Matthew P. Walker, M.D.

MID-LEVEL PROVIDERS
Patrick Anderson, PA-C
Linda Angus, FNP-BC
Heather Conway, FNP-BC
Tasha Elswick, PA-C
Larry Young, PA

Authorization to Obtain Medication History

Patient Name: ______________________

DOB: ____________________________

SSN: _____________________________

Address: __________________________

____

I, ____________________________ hereby authorize ***Neurological Associates, Inc***. to obtain/download my medication history from Pharmacies and/or Pharmacy Benefit Managers. This authorization will allow my physician to check drug to drug interactions for any new prescriptions he/she may prescribe and to facilitate electronic pharmacy prescriptions. I understand this authorization will remain in effect until revoked by me in writing.

____

Date of Authorization

____

Print Name (Patient/Legal Representative or Parent/Legal Guardian)

____

Signature (Patient/Legal Representative or Parent/Legal Guardian)