Communication Consent Form

To provide you with optimum care, it is often beneficial to speak with your current and past health care providers about your case. To ensure your privacy, no communication with other providers will occur without your explicit permission as noted below.

Provider's Name:_____

Provider type: _____

Address:_____

Telephone:_____ Fax:_____

By signing below, I hereby authorize Dr. Mary Fry, N.D. to discuss my medical case with the healthcare provider noted above.

Name (Please Print) _____ Date:_____

Signature of Patient _____

*Signature of Guardian*_____

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