



## 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* \_\_\_\_\_