Communications With Your Medical Doctor

Our office maintains a good working relationship with other health care providers. We want to create bridges with primary care physicians based on communications and trust by providing good clinical information. To do this we need your permission to keep your primary care physician informed about your treatment in this office.

RELEASE INFORMATION:

I hereby give permission to release records regarding treatment with Dr. Brian Ransone, DC at Chiropractic Partners, to my primary care physician for purposes of coordination care.

Signature: _____Today's Date:_____

Patient name (Please print): _____

Name of Primary Care Physician: _____

Optional:

Clinic or Facility Name: _____

Address: _____
_____

Phone Number: _____

Chiropractic Partners
RESTORING HEALTH AND WELLNESS

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