Patient Care Form: Coordination of Services

The purpose of this section is to coordinate with your primary care physician to ensure we are able to provide the most effective standard of care.

- Patient Name *

First Name Last Name

- DOB *

Date

- Primary Care Physician (PCP) Name: *

- PCP Office Name *

- Office Number *

Please enter a valid phone number.

- Fax Number *

- Office Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

- Patient, please check one *

☐ I agree to release information to my physician listed above

☐ I do not agree to release this information to my physician listed above

. ☐ I do not have a primary physician.

- This consent shall expire one (1) year from the date of signature. I understand I may revoke my consent in writing at any time except to the extent that action has already been taken in reliance on it.
- Patient or Legal Guardian Signature *