Physician/Health-Care Provider's Permission Form

Patient Information
Patient Name: ______________________________________ Date of Birth: ________________

Permission Granted to
Provider Name: ___________________________________ NPI#: ________________________
Specialty/Type of Treatment: ____

Reason for Permission
There is no reason to believe that the listed provider's treatments will harm this patient's progress. However, please note the following considerations:

Description of condition: ____

____

Possible Interactions with Medications: ____
____

Special Instructions: ____
____

Permission Granted by
Physician/Health-Care Provider Name: ____
Phone: ___________________ Fax: __________________ Email: ________________________
Signature: _______________________________________ Date: ________________________

Please note: Should you notice anything unusual or significant during treatment, please notify this office immediately. Otherwise, any update at the conclusion of care would be appreciated.