Coordination of Care Request

RE: Patient request for coordination of care between Dr. Garman and

____

Address:____

City: ____________________ State________ Zip: _________

Phone: ______________________________ Fax: ________________________

Email: ____

I authorize Dr. Garman to discuss my care and all information pertaining to my case with the above named person.

____

(Patient Name) (Date of Birth)

____

(Patient Signature) (Date)