

# Medical Provider Information

Dr. Giles feels it is very important that we communicate with your other Health Care Providers as it applies to your case. Please fill in the following information.

Today's concern: \_\_\_\_\_

## Other physicians consulted for this condition

NAME	SPECIALTY	PHONE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Date of last visit \_\_\_\_\_ Their recommendations: \_\_\_\_\_

\_\_\_\_\_

## Other Health Care Providers seen on a regular basis

NAME	SPECIALTY	PHONE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I give authorization to Dr. Troy Giles to share my medical information with the above listed doctors.

Name Printed: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_