

I _____ give permission for Malinda Sanducci, L.Ac. at Dragon Springs Acupuncture to contact my healthcare providers listed below, to discuss my care and treatment, especially when a condition needs to be co-managed with specialists. Coordination of care is for the purpose of managing health conditions in my best interest and assures the optimal outcome of treatment. Therefore, I give my authorization to my acupuncturist to contact my other healthcare providers when necessary.

Practitioners (please list name & specialization):

(Print Name)

(Sign Name)

(Date)