SPINE & NEUROMUSCULAR ASSOCIATES OF S.E.I., P.S.C.

PATIENT NAME:_____

I hereby request and authorize Dr._____ to perform diagnostic tests and render chiropractic adjustments and other treatment to _____. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse / former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DATE: _____

SIGNATURE_____

PRINTED NAME_____

RELATIONSHIP TO PATIENT_____

WITNESS_____