KOZIARSKI CHIROPRACTIC
1535 W 8TH ST SUITE A-5
ERIE, PA 16505
(814)897-3102 FAX (814)616-4375

Authorizations and Releases

CONSENT FOR TREATEMENT

I, the undersigned, hereby authorize Dr. Christopher A. Koziarski, D.C. and whomever he may designate as his assistant(s) to perform diagnostic test and to administer treatment as necessary.

I, also, certify that no guarantee of assurance has been made to the results to be obtained.

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. Furthermore, I understand that this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

***Patient's Signature _____ Date __/__/__Witness_____**

CONSENT FOR TREATMENT OF MINOR

I hereby authorize Dr. Christopher A. Koziarski, D.C. and whomever he designates as his assistant(s), to perform diagnostic tests and to administer treatment he deems necessary to my (indicate relationship to child) _____(child's name)_____.

***Guardian's Signature_____ Date __/__/__ Witness _____**

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____

Print Patient Name **Date of Birth**

I HEREBY AUTHORIZE:

_____

(Doctor/Group/Clinic Name)

TO RELEASE INFORMATION IN MY MEDICAL RECORDS. PLEASE INCLUDE:

___ All my medical records INCLUDING mental health/alcohol and/or drug abuse/HIV/STD
___ All my medical records EXCLUDING mental health/alcohol and/or drug abuse/HIV/STD
___ Specific Records _____Date_____

THESE RECORDS ARE TO BE SENT TO:

_____

/-*This Consent is valid for 1 year, unless revoked by me in writing or verbally before the release of the designated information. Information disclosed pursuant to this authorization may be subject to redisclosure by the individual/organization identified above and is no longer protected by federal privacy regulations.

_____

Patient Signature **Date**