

Date: _____

Patient Name: _____

If deemed necessary for the evaluation and treatment by Georgia Chiropractic Associates or Dr. Craig Steingraber, I authorize the release of my medical records and advanced diagnostic information to Georgia Chiropractic Associates, LLC and Dr. Craig Steingraber.

Patient Signature: _____

If deemed necessary for the evaluation and treatment by other health care providers, I authorize Georgia Chiropractic Associates or Dr. Craig Steingraber, to release my medical records for evaluation.

Patient Signature: _____

If the patient being evaluated and/or treated is a minor, as guardian and/or parent, I authorize the evaluation and treatment of _____.
Name of minor/patient

Parent/Guardian Signature: _____

Parent/Guardian Printed Name: _____

Date: _____