

CHIROPRACTIC FAMILY PHYSICIANS

729 E. Main Street • Easley, SC 29640
Phone (864) 855-1515 • Fax (864) 855-9595

CONSENT TO CARE FOR MINOR CHILD

I hereby authorize Dr. _____, and whomever he / she may designate as
Clinic Administrator
his / her assistants, to administer treatment as deemed necessary to my _____,
Relationship of Child

Complete Name

Dated on _____ day of _____, 20____, at (City) _____, (State)_____.

Signature: _____
Parent or Guardian

Witnessed: _____
Clinic Representative

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RECORDS RELEASE

Date _____

To _____
Doctor or Hospital

Address

I hereby authorize and request you to release

TO:

the complete medical records in your possession concerning my illness and/or treatment during the period from
_____ to _____.

Witness: _____ Signed _____
(Patient or Nearest Relative)

Relationship _____