**AGONA CHIROPRACTIC CLINIC, P.C.**

**AUTHORIZATION**

I hereby authorize Agona Chiropractic Clinic to furnish my records to a requesting facility only upon my request.

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Patient

**NOTICE OF PRIVACY ACT**

I HEREBY ACKNOWLEDGE THE NOTICE OF PRIVACY PRACTICES OF AGONA CHIROPRACTIC CLINIC AVAILABLE UPON REQUEST.

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Patient

**INFORMED CONSENT**

I HAVE BEEN INFORMED AND CONSENT TO CONSULTATION/EVALUATION TREATMENT IF RENDERED.

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Patient

**COVID-19 RELEASE**

By my signature, I do hereby release and hold harmless the AGONA CHIROPRACTIC CLINIC, its employees, agents, and representatives, covenant not to sue, including and liabilities, claims, damages, costs or expenses of any kind arising out of or relating to COVID-19 (coronavirus).

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Signature Date

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Parent/Guardian Signature