AGONA CHIROPRACTIC CLINIC

Dr. Daniel J. Agona, D.C.

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AUTHORIZATION

Authority is hereby given to **Dr. Daniel J. Agona, D.C.** to furnish to my Attorney, Physician or Insurance Company and their representative, copies of any and all records, reports, notes, correspondence, x-rays, test results, or other material or information relating to my consultation, examination, medical history, diagnosis, or treatment and to permit inspection and examination of tangible materials related to examination, diagnosis or treatment.

I understand that my Attorney, Physician or Insurance Company or their representative may make photocopies of this authorization and I hereby authorize the copy to be valid as the original signed authorization.

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Patient

NOTICE OF PRIVACY ACT

I hereby acknowledge that I have read and understand the Notice of Privacy Practices of Agona Chiropractic Clinic.

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Patient

INFORMED CONSENT

I have been informed and consent to treatment.

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Patient