LAKE CITY CHIROPRACTIC CENTER
KEVIN B. HARRISON D.C.

1233 SW State Rd. 47
Lake City, Fl. 32025
OFFICE (386)752-3877 FAX (386)752-3544

DATE: _____ **SS#:_____**

NAME:_____ **DOB:_____**

AUTHORIZATION TO TREAT

I _____ hereby consent to treatment from D. Harrison and whomever he
(Patient Signature)
may designate as his assistant to administer chiropractic care as he deems necessary.

ASSIGNMENT OF PAYMENT-ATTORNEY

I _____hereby authorize and request my attorney to make payment
(Patient Signature)
directly to Dr. Harrison, any monies due to him may be deducted from any settlement made on my behalf.

RELEASE OF MEDICAL RECORDS

I _____hereby request the release of medical records (x-rays, office
(Patient Signature)
notes, reports, etc.) that may be deemed necessary for my treatment with Dr. Harrison- Lake City Chiropractic Center to release any medical information to my insurance company, attorney or anyone else that he deems necessary for my treatment.

ASSIGNMENT OF PAYMENT-INSURANCE COMPANY

I_____ hereby give authorization of benefits to be made
(Patient Signature)