PATIENT NAME: _____

JEFFREY E. POPLARSKI, D.C. LLC.
CHIROPRACTOR
217 MERRICK RD.
SUITE 204
AMITYVILLE, NY 11701
631-598-7034
FAX: 631-598-7479

I hereby request and authorize Dr. Jeffrey Poplarski to perform diagnostic tests and render chiropractic adjustments and other treatment to:
MY MINOR SON/DAUGHTER_____
This authorization also extends to all other doctors and office staff members and is intended to include radiographic examinations at the doctor's discretion.

As of the date, I have legal right to select and authorize heath care services for the minor child named above.

Under the terms and conditions of my divorce, separation, or other legal authorization, the consent of the spouse/former spouse or other patient is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DATE: _____SIGNATURE:_____

PRINT NAME: _____

RELATIONSHIP TO PATIENT_____

WITNESS: _____