**SCHARENBERG CHIROPRACTIC**

**AUTHORIZATION TO TREAT & CARE**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 YOUR NAME (PRINT)

Hereby authorize Dennis R. Scharenberg, D.C. and his staff to administer chiropractic care

as they deem necessary. As of this date, I have the legal right to select and authorize health

care services. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dennis R. Scharenberg D.C.