DIAGNOSTIC X-RAY CONSULTATION SERVICES®

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PATIENT AUTHORIZATION

I consent that my x-rays will be interpreted by Dr. Gary A. Longmuir, chiropractic radiologist, and that a formal written report will be issued to my physician's office to become part of my permanent treatment record. I authorize the release of my medical information necessary to assist in my care at my physician's office.

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Date_____ **Patient's Signature** _____
(Parent or guardian if minor child)

Keep a copy for your records. A photocopy of this form shall be considered as valid as the original.