Williams Chiropractic Center
Dr. Eric P. Williams

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Patient name:_____

This letter is to certify that I give Dr. Eric Williams and his staff the authorization to discuss any information regarding my benefits, treatments, diagnosis, exams, x-rays, any findings, appointments and any care I receive at Williams Chiropractic Center with the following persons: (**please print names**)

_____ _____

Name Name

_____ _____

Name Name

Should I choose to delete or change any of the above authorized persons I must notify *Williams Chiropractic Center* in writing of this information.

X_____ Date_____

Signature