



BOURREE CHIROPRACTIC AND MASSAGE
KIRKLAND PROFESSIONAL CENTER
433 STATE STREET SUITE 6
KIRKLAND, WA 98033

AUTHORIZATION FOR TAKING AND RETAINING X-RAY FILMS

Date: _____

I hereby authorize the taking of analytical x-ray films by the above doctor/clinic and/or staff of such areas as may be of anatomical interest and which may be recommended from time to time by the above doctor or doctors.

Further, I agree that the above doctor/clinic shall be the sole owner of such analytical films and shall remain in custody and in control of said films, until such time as I shall sign a Release Form stating otherwise: such form to be provided by the above upon request.

Signed: _____

Parent or Guardian (if applicable): _____

Witness: _____

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual cycle: _____

Signature: _____ Date: _____