



Great Lakes Chiropractic of St. Michael

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## **AUTHORIZED PEOPLE WHO HAVE ACCESS TO MY INFORMATION**

I authorize Great Lakes Chiropractic of St. Michael to share my account information including TREATMENT DETAILS, ACCOUNT INFORMATION, PAYMENT DETAILS, AND APPOINTMENT TIMES with the following people. (spouse, parent, children)

\_\_\_\_\_  
NAME

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

\_\_\_\_\_  
NAME

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

\_\_\_\_\_  
NAME

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

**Please do NOT allow anyone to access my information**

*This is valid until revoked or changed by written communication.*

\_\_\_\_\_  
**SIGNATURE OF PATIENT (OR RESPONSIBLE PARTY, IF MINOR)**

\_\_\_\_\_  
**DATE**