CLARKE PHYSICIANS

OKLAHOMA

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Tulsa, OK 74135
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AUTHORIZATION FOR MEDICAL TREATMENT (OKLAHOMA)

I, the undersigned, a patient at this clinic, hereby authorize Dr. Washatka DO, and whomever she may designate as her assistant, to administer examinations and treatment as is necessary, and to perform therapy and adjustments and such additional therapy or procedures as are considered therapeutically necessary during the course of said treatment.

I hereby certify that I have read and fully understand the above Authorization for Medical Treatment. The reasons that the above named treatment are considered necessary, the advantages and possible complications, if any, as well as possible alternative modes of treatment which are explained to me by Dr. Washatka or whomever she designates, and I certify that no guarantee or assurance has been made as to the results that may be obtained. I also understand that any supplements that are recommended for me are an aid in supplying the body those nutrients that the physician has determined may be of benefit to me.

DATE: _____

SIGNED: _____

WITNESS: _____