

## **PREGNANCY RELEASE FORM**

This is to certify, that to the best of my knowledge, I am not pregnant and I hereby give my full and complete permission to the Doctors at ReAlign Chiropractic, P.C. to take my x-rays.

Date of Last Menstrual Period \_\_\_\_\_

Patient Name \_\_\_\_\_

Patient Signature \_\_\_\_\_

Today's Date \_\_\_\_\_

Witness Signature \_\_\_\_\_