Crestwood Pediatric Associates, PC

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P: (703) 753-6184 Fax: (703) 753-2988

AUTHORIZATION FORM

Patient Name (s): _____

_____

I, _____, authorize the below listed person(s) to bring my child
(Parent/Guardian)
to office visits, complete paperwork, and consent to treatment and/or vaccinations in my absence:

1. Name_____ Relationship_____Ph:_____
2. Name_____ Relationship_____Ph:_____
3. Name_____ Relationship_____Ph:_____
4. Name_____Relationship_____Ph:_____

I authorize Crestwood Pediatric to discuss my child/children's medical records, immunizations, or other health information with the following schools and/or daycares: _____

_____

_____

This authorization is valid until I notify the office otherwise.

Please contact me with any questions or concerns:

Name _____ Phone_____

Signature: _____ **Date:** _____