

Crestwood Pediatric Associates, PC

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Gainesville, VA 20155
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AUTHORIZATION FORM

Account #: _____

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 _____

2. Name _____ Relationship _____

3. Name _____ Relationship _____

4. Name _____ Relationship _____

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:** _____