

# Crestwood Pediatric Associates, PC

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## **AUTHORIZATION FORM**

Please list **all** children (under 18 years old) that come to our practice:

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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:

**Please list family members other than parents:**

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_ Ph: \_\_\_\_\_

2. Name \_\_\_\_\_ Relationship \_\_\_\_\_ Ph: \_\_\_\_\_

I authorize Crestwood Pediatric to discuss medical information with the following schools and/or daycares.

**School/Daycares:**

1. Name \_\_\_\_\_ Ph: \_\_\_\_\_

2. Name \_\_\_\_\_ Ph: \_\_\_\_\_

**This authorization is valid until I notify the office otherwise.**

Name \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_