The Pediatric Sleep Center
205 East Hirst Road, Suite 303
Purcellville, VA 20132
Tel: (703) 226-2290 or (540) 751-1955
Fax: (540) 751-1954

Medical Permission Form

The purpose of this form is to authorize other adults **18 years of age or older** to bring your child to this practice for medical treatment and services. Please complete one form for each child you wish covered by the Medical Permission Form.*

I, ________________________, give permission for the individual(s) listed below to bring my
Parent/Guardian's first and last name

child, __________________________ _______________ for office visit(s) and to make
Child's first and last name Child's Date of Birth

medical decisions on my behalf for my child. I understand that this individual may be required to sign the financial responsibility statement, pay the necessary co-pay and provide proof of identification to practice staff before my child is seen.

____
Authorized Adult's Name (Please print clearly)

____
Authorized Adult's Name (Please print clearly)

____
Authorized Adult's Name (Please print clearly)

PLEASE CHECK ONE:

❒ Permission is for all future visits my child has at this practice or until I request this authorization be removed.

OR

❒ Permission is in effect for the following date(s) or date range: ________________________.

Parent/Guardian Name (PRINT) ____

Signature ____

Date ______________________________ Relationship to Patient __________________________

*The HIPAA Privacy Rule and our policies and procedures allow us to obtain verbal agreement from you to use and disclose to an individual involved in the patient's care any medical or billing information relevant to that patient's health care.