UNION MILL PEDIATRICS, P.C
13880 Braddock Road, Suite 201
Centreville, Virginia 20121
(703) 802-6304
(703) 802-6307 FAX

Maura Eriksson, M.D.
Wayne Eriksson, M.D.
Shoshana Killian, M.D.
Pooja Dhananjayan, M.D.

MEDICAL AUTHORIZATION FORM (CHILD)

This form is to be used to authorize other adults **over 18 years of age** to bring your child to this practice and to seek treatment. Please complete one form for each child you wish covered by this authorization.

I, _____, give permission for the individuals

listed below to bring my child,_____ _____,
FIRST/LAST/MIDDLE DATE OF BIRTH

for office visits and to make medical decisions for my child, including signing for any immunizations.

_____ I understand that any authorized person will be required to pay any necessary copay, and is responsible
Initial to identify himself/herself to the staff as an authorized person upon arrival to the practice. They will need to have proof of identification.

_____ I understand that if I choose to have my co-pay billed to me there will be an additional $10 billing fee
Initial added to the cost.

_____ _____
Authorized Adult's Name (PLEASE PRINT CLEARLY) Relationship to Patient

_____ _____
Authorized Adult's Name (PLEASE PRINT CLEARLY) Relationship to Patient

_____ _____
Authorized Adult's Name (PLEASE PRINT CLEARLY) Relationship to Patient

_____ _____
Authorized Adult's Name (PLEASE PRINT CLEARLY) Relationship to Patient

PLEASE CHECK ONE:

☐ Authorization is for all future visits or until I request this authorization be removed

☐ Authorization in effect for the following dates _____

Parent/Guardian Name (PRINT) _____

Signature _____

Date _____