Northwest Pediatric Center

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AUTHORIZATION FOR EXCHANGE OF INFORMATION PERTAINING TO MEDICAL CARE

Patient's Name: _____ **DOB:** _____

As parent or legal guardian of the above named child, I hereby give my consent to authorize mutual exchange of information in writing or by verbal communication between the following individuals:

_____

(your child's school district should be written here)

and Northwest Pediatric Center, Inc., for the purpose of evaluation, treatment, and follow-up of my child's medical condition, which has been described to me as:

Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder
Also known as ADD or ADHD

By signing below, I authorize the mutual exchange of information pertaining to the above conditions(s), with consent granted until such time as I revoke my permission in writing.

_____ _____
Parent or legal guardian signature **Date**

_____ _____
Print Parent or legal guardian name **Date**