Northwest Pediatric Center
1911 Cooks Hill Road · Centralia, WA 98531
Phone: (360)-736-6778 · Fax: (360)-736-6552

MUTUAL AUTHORIZATION

(AUTHORIZATION FOR EXCHANGE OF INFORMATION PERTAINING TO MEDICAL CARE)

Patient's Name: _____ DOB: _____/_____/_____

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

School Name: _____

Academic Teacher (morning): _____

Academic Teacher (morning): _____

Academic Teacher (afternoon): _____

Academic Teacher (afternoon): _____

and Northwest Pediatric Center 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 condition(s).

_____ _____/_____/_____
Parent/Guardian Signature Date

_____
Parent/Guardian Name (Print)

PATIENTS 13 YEARS and OLDER MUST SIGN

By signing below, I authorize the mutual exchange of information pertaining to the above condition(s),

_____ _____/_____/_____
Patient Signature Date

_____
Patient Name (Print)