To Whom It May Concern

Regarding Patient:

I, _____(parent of patient), give my permission for_____, to accompany my child, _____ to appointments at the ADD/ADHD Diagnostic and Treatment Center.

This authorization includes my permission for_____to make decisions regarding testing and evaluations, starting medication for treatment if her doctor recommends it, possible dosage changes in the process of regulating medication to correct levels, and any other decisions required in the evaluation or treatment of my child.

I, _____, (patient's parent) understand, in order to avoid any misunderstandings or confusion regarding my child's care, if/when I have questions or concerns, all test results, treatment plans, medication issues or any other information regarding my child's evaluation and/or treatment at the ADD/ADHD Diagnostic and Treatment Center, ***will only be discussed*** with me in person, (per his/her doctor's discretion) at an office visit with his/her doctor. I also understand the ADD/ADHD Diagnostic & Treatment Center is ***NOT*** responsible for any miscommunications that might occur when the person bringing my child relays content of any appointments in the ADD/ADHD Diagnostic & Treatment Center office to myself (patient's parent).

_____ **(Parent Signature)**

_____ **(PRINT Parent's Name)**

DATE: _____ / _____ / _____