Joint Medical Decision Making Rights

I am the divorced parent of the patient_____.
Print Patient's Name

I give my ex-spouse_____ permission to make medical decisions
Ex-Spouse's Name

on my child's behalf while receiving care at the Autism Allies when I am not present.

_____ _____
Parent Signature Date

I understand that we must manage appointment times and treatment to make joint medical decisions on the behalf of our child _____. I understand that
[Patient's name]
Autism Allies will not serve as mediators of any discrepancies of treatment or appointments. I also understand that if we as the parents of the patient are unable to come to an agreement on the child's care, Autism Allies will discharge my child from the practice until the treatment plan is resolved by both parties.

_____ _____
Guardian Signature Date

_____ _____
Guardian Signature Date

AA Staff Witness Signature and Date_____