Consent for Psychological Services

(please present at first visit)

Name of Person Giving Consent:_____

Your Relationship to Child (check one):

[ ] Parent [ ] Stepparent [ ] Grandparent
[ ] Guardian [ ] Other:_____

Does the consenting adult have legal custody of the child: [ ] Yes [ ] No
IF Yes, is it [ ] joint or [ ] individual custody?
IF NO, who is the legal custodian? _____

Name of Child:_____ Date of Birth:_____

I, _____, consent to the following

psychological/psychiatric services for the child named above:

Check and Initial All That Apply

[ ] Clinical Interview/Evaluation
[ ] Counseling/Psychotherapy
[ ] Other _____
[ ] Psychological Testing
[ ] Psychiatric Evaluation/Medication

_____ _____
Printed name of person giving consent Date

_____ _____
Signature of person giving consent Date

_____ _____
Signature of Witness Date