CONSENT FOR PSYCHOLOGICAL SERVICES TO CHILD(REN)

Name of person giving consent:_____
PLEASE PRINT

Your relationship to child(ren) (circle one):
Parent Step-parent Grandparent Guardian Other

Name(s) and date(s) of birth of child(ren) receiving services:

Name:_____ Date of birth:_____

Name:_____ Date of birth:_____

Name:_____ Date of birth:_____

Name:_____ Date of birth:_____

Are you the legal custodian of the above children? Yes___ No___

If you are a divorced parent, step-parent, grandparent, guardian or other, have you brought a copy of the court order which names you as the legal custodian of the above named child(ren)? Yes_____ No_____

If any of the answers to the above two questions is NO, psychological services cannot be provided to the above named child(ren) until a copy of the court order which names you legal custodian is provided to this office.

I, _____, consent to
Moreen W. Foster, M.A.P.C.C. to provide psychological services for the child(ren) named above. These services may include:

____clinical interviews of the child(ren)
____psychological testing of the child(ren)
____counseling/psychotherapy
____other services listed below:

_____ _____
Signature of person giving consent Date