

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 Nancy McReynolds, L.A.D.C., C.E.D.S., 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