Psychological Center for Growth and Development

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PATIENT CONSENT FOR USE AND DISCLOSER OF HEALTH INFORMATION

____________________________ ________________________

Patient Name Patient's Date of Birth

____________________________ ________________________

Parent/ Legal Guardian's Name Phone Number (daytime)

I hearby authorize the psychologists and staff of the Psychological Center to furnish any appointments, test results, or medical information to the following individuals.

Name:______________________________ Relationship:______________________

Name:______________________________ Relationship:______________________

Name:______________________________ Relationship:______________________

Name:______________________________ Relationship:______________________

I consent to treatment including counseling, testing, and any other treatment rendered at this office if the above listed bring my child to this office. I understand that I waive the specific time allotted to meet with the guardian of a child during the session and will furnish any questions or concerns to the person bringing my child to this appointment. I understand that phone consultations are not included in my child's care and if I am unavailable during their appointment time I may be billed if I call for a telephone consult with the psychologist regarding my child. The standard fee for this consultation is $20.00 per 15 minutes and WILL NOT be covered by insurance.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

____________________________ ________________

Signature of Parent/Legal Guardian Date