

Authorization for Evaluation and Treatment

Please print:

Child's Name: _____ **Child's Date of Birth:** _____

Parent(s)/Guardian: _____

Relationship to Child: _____

I/We, _____, hereby give full consent for my/our child and/or myself/ourselves to receive psychological evaluation and treatment services of Diane D. Barghi until I/we notify her or until she determines that services are no longer appropriate or will no longer be provided.

I/We further certify that I/we have the legal authority to authorize and consent to this evaluation and/or treatment as parent(s), managing conservator, or guardian(s) of this child.

I/We understand that any information that I/we provide to Diane D. Barghi is confidential and generally will not be released to others without my/our written consent. However, I/we understand that state and/or federal law might require Diane D. Barghi to disclose confidential information without my/our consent in certain circumstances. I understand that Diane D. Barghi may be required to disclose confidential information, without the consent of a client or a client's legally authorized representative, in one or more of the following situations: (1) if a client is evaluated to be a danger to self or others; (2) if Diane D. Barghi believes a child is the victim of abuse or neglect; (3) if information is disclosed about the physical or sexual abuse or neglect of a child, elder, or disabled person; (4) if a suit is filed by me/us or my/our child against Diane D. Barghi for breach of duty; and (5) if a court order, legal proceeding, statute, or regulation requires disclosure.

I/We understand that I/we will not receive a copy of my/our child's records without the approval of Diane D. Barghi or another authorized professional.

My/Our signature on this consent form verifies that I/we have had the opportunity to ask questions regarding Diane D. Barghi's policies, procedures and therapy techniques, that my/our questions were answered to my/our satisfaction by Diane D. Barghi, and that I/we voluntarily give my/our consent for treatment. I/we understand that I/we have the right to withdraw my/our consent for treatment at any time.

Parent/Guardian's Signature

Date

Printed Name of Parent/Guardian

Relationship to Child

Parent/Guardian's Signature

Date

Printed Name of Parent/Guardian

Relationship to Child