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Consent for Psychological Services to Children

Name	Date of Birth	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I, _____, am the legal custodial parent of the child(ren) listed above. I consent to the following psychological services for the child(ren) named above.

Some or all of the following may be used.

- Clinical Interview of the child(ren)
- Psychological testing of the child(ren)
- Parent Interviews
- Interviews of people from the contact lists submitted by the parents
- Interviews with physicians or mental health professionals
- Interviews with stepparent or noncustodial parent
- Observations of the child(ren) with parents

Your relationship to the child: ___Parent ___ Stepparent ___ Grandparent ___ Other

Signature of person giving consent Date

Evaluator Signature Date