



Consent to Evaluation Form

I, agree to undergo (or I give consent for this person, _____, to undergo) a complete psychological/psychiatric/mental health/family evaluation at the direction of this third party: _____ . I understand and agree that the results of this evaluation are to be the sole property of this third party. I agree that I will not hold this third party legally responsible for any events resulting from this evaluation or the records created by it.

I understand that the purpose(s) of this evaluation are:

1. _____
2. _____
3. _____

I understand and agree that no doctor-patient or therapist-client relationship exists or will be created between myself (or the person being evaluated) and the evaluator.

I understand that I may withdraw my consent to this evaluation and to the transfer of information at any time by means of a written letter. However, I also understand that my withdrawal will not be retroactive (that is, it will not apply to testing and information transfer that have already taken place). If I do not withdraw my consent, it will automatically expire in 90 days from the date I signed this form.

I agree that a photocopy of this form is acceptable, but that the photocopy must be individually signed by me and a witness. I understand I have the right to receive a copy of this form upon my request.

Signature of client (or custodial parent/guardian of young child) Date

Printed name

Signature of adolescent client Date

Printed name

I, the psychologist, have discussed the issues above with the client (and/or his or her parent or guardian). My observations of this person's behavior and responses gives me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of psychologist Date

Copy accepted by client Copy kept by psychologist

This is a strictly confidential patient medical record. Rediscovery or transfer is expressly prohibited by law.