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INFORMED CONSENT

Name of Client: _____ D.O.B. _____

After reading this carefully, please indicate your understanding and consent by signing your name and date in the space provided.

If you have any questions, please feel free to discuss them with the clinician/psychologist. Your signature below serves as Authorization for outpatient services. These services may involve psychological evaluation and testing, and/or therapy. This Authorization has been made freely and voluntarily.

Confidentiality

All information you share about yourself will be kept confidential. Without your written permission, no information will be released to anyone outside of this agency. The only exceptions to this policy are situations involving imminent danger to you (client) or someone else, suspicion of child abuse, or possibly, if the information is mandated by court order.

As applicable, information will also be shared with the supervising licensed psychologist reviewing the final report. The current evaluator has obtained their Master's or Doctoral Degree in Psychology, and if not licensed, is currently practicing under the supervision of a Licensed Psychologist. Should you have any concerns that would be most appropriately addressed by a supervisor, the supervising psychologist can be contacted at (717) 391-6808.

Policy on Review of Psychological Evaluation Results

Because a psychological evaluation provides considerable information on the behaviors and level of functioning of an individual, we encourage the client, or parent(s)/guardian(s) in case of a child, to review the results with a psychologist. This will provide an opportunity for you to discuss issues and questions surrounding the evaluation results.

Consent of both parents/guardians may be required for treatment

In some cases we require the consent of both parents in order to evaluate or treat your child. These include:

1. Cases where there is shared custody for separated or divorced parents.
2. Situations in which the noncustodial parent retains rights to make or participate in medical decision for the child.
3. Situations in which there is no formal custody agreement and parents are separated or divorced.

	By initialing this box, I certify that none of the three conditions above apply

I have read this form and understand and consent to the policies and responsibilities stated therein.

_____ _____ _____
Signature of client or his or her personal representative | Printed name of client or personal representative | Date Signed

_____
Description of personal representative's authority

Consent-sup rev. 03/21/08