PROFESSIONAL
PSYCHOLOGICALSOLUTIONS
PLLC

CONSENT FOR TREATMENT

_____ _____

Client Name Date of Birth

I give consent for (psychological assessment / psychotherapy) for the above named client. I understand that these procedures include interviews, collateral contacts (with written consents for release or exchange of information), and ongoing therapy notes. I understand that the information obtained from these procedures will be used to formulate diagnostic impressions and recommendations in response to those questions for which services are requested, as well as to facilitate ongoing therapeutic interventions.

I understand that any information from these procedures is confidential and may be released to third parties only upon my written consent with the following exceptions:

A. Results of the assessment and/or psychotherapy may be subject to subpoena, and testimony may be required by a court of law, and/or

B. Results of the assessment and/or psychotherapy may be subject to discovery by parties to any suit regarding a parent-child relationship, and/or

C. Suspected child abuse and neglect MUST be reported to the Texas Department of Protective and Regulatory Services, and/or

D. Behavior that is an imminent danger to self or others MUST be reported.

Information collected and gathered in your medical records is considered “Protected Health Information” about you and/or your family members. Your privacy is maintained in compliance with HIPPA rules and regulations. I hereby discharge Sylvia G. Garza, Ph.D., LSSP, NCSP, from any legal liability in such cases where information must be released.

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Signature of Client Date