CONSENT FOR TREATMENT OF MINOR

Child's Name:_____Date of Birth:_____

Child's Name:_____Date of Birth:_____

I, _____, am the sole legal custodial parent of the above named child (or children) and give my permission to Laurie Appel, Psy.D to provide psychological services to my child (or children). I fully understand the nature and purpose of these services, including possible benefits and risks, and have discussed any concerns with Dr. Appel. I understand that it will be expected that I provide a copy of any divorce agreement, if relevant, to give evidence of the custody arrangements. **It is understood that if this case is taken to court for any reason, I CANNOT render an opinion on custody.**

Parent_____Date_____

Witness_____Date_____

We, _____, are the joint legal custodial parents of the above named child (or children) and give our permission to Laurie Appel, Psy.D to provide psychological services to our child (or children). I fully understand the nature and purpose of these services, including possible benefits and risks, and have discussed any concerns with Dr. Appel. **It is understood that if this case is taken to court for any reason, I CANNOT render an opinion on custody.**

Parent_____Date_____

Parent_____Date_____

Witness_____Date_____