Randi Most, Ph.D., ABN
ψ Board Certified Neuropsychologist

PERMISSION FOR SERVICES

I, _____, give Dr. Most permission to provide neuropsychological and/or psychological services to myself; or to my minor child _____. I hereby attest to the fact that I have legal custody of the above named child.

Limits of Confidentiality

I understand that psychological records are considered privileged and exempt from disclosure under applicable law. I further understand that Dr. Most is required by law to forgo confidentiality, and report to the appropriate state agencies, all instances of abuse to children or senior citizens. Confidentiality may also be broken in circumstances where an individual is considered a danger to themselves or another person. Furthermore, I understand that Dr. Most is required to release my records if court-ordered to do so by a judge.

Risks and Benefits

Psychotherapy and diagnostic evaluations can have benefits and risks. Since both often involve discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Neuropsychological and psychological exams can help to clarify your diagnosis and result in beneficial treatment recommendations. But there are no guarantees of what you will experience.

This authorization is given voluntarily with mental competency and knowledge of purpose, and free from undue influence or duress. I understand that I may withdraw this consent at any time.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature Date
(if patient is a minor)

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