

AUTHORIZATION FOR EVALUATION AND TREATMENT
OF MINORS OR ADULT DEPENDENTS

I certify that I am the parent or legal custodial guardian of
_____ who is a minor dependent.

Date

Signature

I authorize HealthQuest, P.C. to conduct a psychological evaluation of
_____. Such an evaluation may include, but is not limited to
personal interviews, psychological tests, review of treatment records, and other generally
accepted practices in the fields of psychology and social work.

Date

Signature

I authorize HealthQuest, P.C. to provide psychological treatment to
_____. Such treatment may include, but is not limited to, individual
psychotherapy, group treatment, family therapy, or specialized therapeutic procedures
which are generally accepted in the fields of psychology and social work.

Date

Signature