LD Neuropsychological Services

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Consent for Treatment for Minors

I, ________________________, give my consent that Lana Delshadi, Ed.D. will be conducting

Neuropsychological/ Psychological Testing with ______________________________.
My relationship to the client is (parent, guardian, aunt, uncle, etc.):

______________________________.
I was notified that the holder of the privilege is (parent, legal guardian aunt, uncle, etc.)

______________________________.

I was also notified that all material discussed during the Neuropsychological / Psychological Testing is confidential and can be released **only** with the permission of the holder of the privilege. I have been informed of the limitation to confidentiality in the Office Policies Form, which I have read and signed.

In case of a minor, special sensitivity may be required in releasing information about certain topics such as drugs and sex. I will accept Dr. Lana Delshadi's judgment in regard to releasing or sharing information obtained during the course of Neuropsychological / Psychological Testing with the minor that may endanger or jeopardize the patient's well-being.

Patient Name: ____ DOB: ________________

_________________________ ___________ _______________________ ___________
PARENT/GUARDIAN NAME (PRINT) RELATIONSHIP PARENT/GUARDIAN SIGNATURE DATE

_________________________ ___________ _______________________ ___________
PARENT/GUARDIAN NAME (PRINT) RELATIONSHIP PARENT/GUARDIAN SIGNATURE DATE