PHOENIX HEALTHCARE OF VIRGINIA, LLC

Sondra B. Harry, PsyD

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AUTHORIZATION FOR THE TREATMENT OF A MINOR

I,_____, am the parent or legal guardian of

_____, whose date of birth is _____.

I have legal custody or hold valid written authorization to act on behalf of this minor.

I authorize Dr. Sondra Harry, a Licensed Clinical Psychologist, to evaluate and/or perform appropriate psychological assessment and treatment, and I assume all financial responsibilities with regard to the evaluation, assessment and treatment or this minor.

I understand that the evaluation, assessment, and treatment of this minor may indicate a need for further parent/guardian sessions and/or family involvement. I also understand that Dr. Harry will utilize appropriate and acceptable treatment methods in keeping with the code of ethics and guidelines of the American Psychological Association (APA). I understand that I will be notified of any evaluation, assessment, or treatment that deviates from APA guidelines.

I understand that this authorization for treatment may be revoked by me at any time should the need arise and that this authorization will be automatically revoked at the termination of treatment.

Signature of Parent/Legal Guardian:_____Date:_____

Print Name:_____Date:_____

Signature of Adolescent:_____Date:_____

Print Name:_____Date:_____

Signature of Witness:_____Date:_____

Printed Name:____Date:_______________