

PHOENIX HEALTHCARE OF ASHEVILLE, PLLC
Sondra B. Harry, PsyD
2149 Riceville Rd., Asheville, NC 28805

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.

I assume all financial responsibilities with regard to the evaluation, assessment and treatment of 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 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: _____