

**Washington Psychological Services
87 East Maiden Street
Washington, PA 15301
724-222-8525 Fax: 724-222-8545**

Consent To Psychological Evaluation

By consenting to this evaluation, you are entitled to a complete evaluation and written report. Treatment recommendations will include consideration of the client's family, community and culture. Further, treatment recommendations will be formulated to meet the client's needs in the least restrictive and least intrusive manner possible so as to achieve expectations of progress toward treatment goals.

All individuals present for the evaluation have the right to be treated with respect and dignity and the right to confidentiality throughout the evaluation process. This means that the information provided by family members during the interview and data gathered from assessment measures will not be shared with anyone, except for the following reasons and purposes:

1. Release of Information Agreements: Evaluator can release information to third parties at the request and after a release of information agreement has been signed by the client or parent/guardian.
2. Evaluator adheres to the Pennsylvania Child Welfare Agency's legal duty to report any suspicion of physical or sexual abuse or neglect of minors.
3. Evaluator is required by law to report information regarding a child or is a danger to himself/herself or others.

I, _____, understand that I am consenting to this evaluation under the terms outlined above.

Client Signature: _____ Date: ____ / ____ / ____

Witness: _____ Date: ____ / ____ / ____