CONSENT FOR TREATMENT WITH A [PSYCHOLOGICAL ASSISTANT/INTERN]

I,_____, authorize and request that _____, an unlicensed [psychological assistant/Intern] under the direct supervision and employment of _____, [Ph.D./ M.D./ M.F.C.C.], [a licensed psychologist/ licensed physician/ licensed marriage, family and child counselor], carry out psychological *examinations, treatments* and/or diagnostic procedures which now or during the course of my care as a patient are advisable.

I understand that the purpose of these procedures will be explained to me and be subject to my agreement.

I, _____, hereby give my written consent to have _____, an unlicensed [psychological assistant/intern], disclose any medical, psychological or personal information concerning me to _____, [Ph.D./ M.D./ M.F.C.C.].

This authorization expires on _____.
It may be revoked at any time by written notification to _____[Ph.D./M.D./M.F.C.C.].

I have read and fully understand this Consent For Treatment Form.

_____
DATE Client Signature

_____
DATE Supervisor Signature

_____
DATE [Psychological Assistant/Intern] Signature