

## Consent and Agreement for Mental Health Testing and Evaluation

I, \_\_\_\_\_ agree to allow the mental health professional named below to perform the following services:

- Mental health testing, assessment, or evaluation
- Report writing
- Consultation with school personnel
- Consultation with lawyers
- Deposition (that is, written testimony given to a court, but not made in open court)
- Testimony in court
- Other (describe):

This agreement concerns  myself or

I understand that these services may include direct, face-to-face contact, interviewing, or testing. They may also include the mental health professional's time required for the reading of records, consultations with other mental health professionals, scoring of tests, interpreting the results, and any other activities to support these services.

I understand that this evaluation is to be done for the purpose(s) of:

- 1.
- 2.

I also understand the mental health professional agrees to the following:

1. The procedures for selecting, giving, and scoring the tests, interpreting the results, and maintaining my privacy will be carried out in accord with the rules and guidelines of the American Psychological Association and other professional organizations.
2. Tests will be chosen that are suitable for the purposes described above. These tests will be given and scored according to the instructions in the tests' manuals, so that valid scores will be obtained. These scores will be interpreted according to scientific findings and guidelines from the scientific and professional literature.
3. Tests and test results will be kept in a secure place to maintain their confidentiality.

I agree to help as much as I can, by supplying full answers, making an honest effort, and working as best I can to make sure that the findings are accurate.

Nothing in this Agreement creates a therapy relationship or a doctor-patient relationship. A therapy relationship or a doctor-patient relationship requires a separate agreement in writing.

\_\_\_\_\_  
Signature of client (or parent/guardian)

\_\_\_\_\_  
Date

I, the mental health professional, have discussed the issues above with the client (and/or his or her parent or guardian). My observations of this person's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent.

\_\_\_\_\_  
Signature of mental health professional

\_\_\_\_\_  
Date

Copy accepted by client  Copy kept by mental health professional

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.