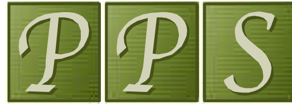


PREMIER PSYCHOLOGICAL SERVICES

AUTHORIZATION AND RELEASE FOR THE EVALUATION AND TREATMENT OF A MINOR

We, the undersigned, do hereby agree to have our child ___________________________ evaluated, tested and/or treated by a licensed psychologist at Premier Psychological Services (PPS). As biological parents or legal guardians, we each have the right to request information concerning the above minor's evaluation and/or treatment and will each receive copies of any screening reports, findings, or recommendations.

This authorization will remain in effect unless either party below notifies PPS, in writing that they wish to discontinue any and all services for their child listed above. This notification must be acknowledged by Premier, either by being signed by a PPS therapist in person or by mail, using a Certified Return Receipt notification. The notification will become effective two days after date of receipt.

____ ________________

Biological Mother Date

____ ________________

Signature – Mother Date

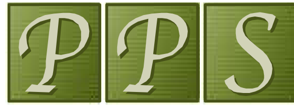
____ ________________

Biological Father Date

____ ________________

Signature - Father Date

The River Oaks Tower · 3730 Kirby Drive · Suite 800 · Houston, Texas · 77098
713-521-7575 Office 713-521-7576 Fax



PREMIER PSYCHOLOGICAL SERVICES

NOTIFICATION FOR DISCONTINUANCE OF TREATMENT OF A MINOR

We, the undersigned, request that all treatment being administered by Premier Psychological Services (PPS) therapists, be discontinued per PPS's policy which is two days after acknowledged receipt of this notification.

______________________________________ ____________________
Signature – Mother Date

______________________________________ ____________________
Signature – Father Date

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