Tiffany Griffiths, Psy.D. & Associates, Inc.

Consent for Testing -Independent Educational Evaluations

Name of client :_____

This is to certify that I give permission to Tiffany Griffiths, Psy.D. & Associates, Inc. to perform an independent educational evaluation. I understand that my case may be discussed during peer consultation meetings and as necessary with other licensed colleagues for consultation purposes. Identifying information will not be used so as to protect my privacy in these cases. In addition, I understand that the results of the evaluation will be shared with my school district.

I will be treated with respect and honesty throughout the evaluation process. I understand that although the school district has agreed to pay for this evaluation, payment for services is ultimately my guarantor's responsibility and a report will not be released until payment in full is received. Tiffany Griffiths, Psy.D. & Associates, Inc. also reserves the right to use appropriate agencies to collect delinquent payments after 90 days and I understand that my guarantor will be responsible for any fees incurred for returned checks and/or the fees of such agencies.

While under most circumstances all communication between the client and evaluator is confidential, Pennsylvania State Law mandates the reporting of actual or suspected abuse to the appropriate agency. It has also been upheld that if an individual intends to take harmful or dangerous action against another, it is the therapist's duty to warn the person or the family of the person who is likely to suffer the results of harmful behavior. Similar actions are taken with clients who may have had suicidal thoughts and desires. Every reasonable effort will be made to appropriately resolve these issues or to notify the client before such a compromise of the client-evaluator relationship is made. Furthermore, if a third party such as a medical doctor or attorney requests the evaluation it will not be released until I sign a release of information (consent) form. I do understand that in order for the above evaluators to gain as broad of an understanding of my needs they do need to rely on collateral sources such as my teachers and pediatrician/physician for their feedback. I consent to the gathering of information from these sources as well as other sources (to be identified) deemed necessary for the purposes of this evaluation.

_____ ____/____/____
Name of patient Date

_____ ____/____/____
Signature of patient Date