Kathleen Adams, Ph.D.
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Austin, Texas 78746
(512) 327-8311
Clinical Psychologist
Texas License #1596

AUTHORIZATION FOR SERVICES

I, _____, hereby authorize Dr. Kathleen Adams to provide diagnostic evaluations, consultations, and/or psychological services for _____ beginning on the date _____/_____/_____. I understand that this authorization may be revoked at any time.

In the event that an insurance company is responsible for payment for services, I also hereby give authorization to release any information necessary to satisfy medical insurance claims.

_____ _____
Signature of Patient/Legal Guardian* Date

_____ _____
Signature of Patient/Legal Guardian Date

*I stipulate that in the event of divorced parents, I have full custody and the right to make medical decisions for my child. I have provided a copy of the legal paperwork documenting this status.