Contact Information Sheet

Dr. Raymond M. Fuchs, Ph.D.
Suite 518 Midtown Plaza
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Office (405)217 2964
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Must have a copy of completed form for each legal guardian/parent of the minor. Can send to Dr. Fuchs' Office via:
Fax: 405-217-2408 or
Email: ray4fuchs@att.net

CONSENT FOR PSYCHOLOGICAL EVALUATION & PSYCHOTHERAPY FOR MINOR CHILD

(Please print all information)

I, ____, parent or legal guardian of
Your Name

____, born _________________________,
Child/Patient's Name Child's Date of Birth

do hereby consent to psychological evaluation and psychotherapy treatment as determined by Licensed Psychologist, Dr. Raymond M. Fuchs, Ph.D., to be necessary for the welfare of my child while said child is under the care of _______________________________ .
Other Guardian Name

This authorization is effective from _______________ to _______________.
Today's Date One year from Today's Date

____
Printed Name of Guardian Signing

____
Phone Number of Guardian Signing

____
Address of Guardian Signing

____
City, State & Zip of Guardian Signing

____ ____________________
Signature of Guardian Date