Jessica L. Long, Psy.D.

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Special Authorizations for EVALUATIONS

CLIENT NAME: ____ CLIENT's **DATE OF BIRTH**: ________________

Parent/Guardian: ____

Please initial each accordingly.		
I **DO** Authorize	I do **NOT** Authorize	**The office of Jessica Long, Psy.D to:**
_____	_____	Communicate via email with school personnel and me/my child's caretakers to arrange and send electronic links for online rating scales. I understand these emails will include no identifying information other than name and acknowledgement of counseling/evaluation services being provided to me/my child. I realize that email is not a completely secure method of contact and that I have the right to request an alternative method.
_____	_____	To photograph or record me/my child for the purpose of identification and evaluation accuracy. For example, the evaluator may record my child's responses to ensure proper scoring.

____ ____________________

Client Signature Date
(If client is 13 years of age or older, he/she must sign consent)

____ ____________________

Parent/**Guardian** Signature Date
(for minors 12 years of age and under)