Piper Walsh, Ph.D.
Clinical Psychologist, PSY 21232
A Professional Psychology Corporation
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AUTHORIZATION TO TREAT A MINOR CHILD

I hereby give consent to psychological evaluation and treatment of my minor Child, _____, by Dr. Piper Walsh.

I understand and accept that custody evaluations are not part of Dr. Walsh's practice. I understand and accept that Dr. Walsh will not voluntarily participate in any litigation or custody dispute in which client and another individual, or entity, are parties. I accept Dr. Walsh's policy of not communicating with clients' attorneys and accept that she will not write or sign letters, reports, declarations, or affidavits to be used in clients' legal matters. I accept that she will not generally provide records or testimony unless compelled to do so. Should she be supoenaed, or ordered by a court of law, to appear as a witness in an action involving a client, I agree to reimburse her for any time spent for preparation, travel, or time in which she makes herself available for such an appearance at the rate of $500 dollars an hour.

_____ Date_____
Legal Custodial Parent, guardian

_____ Date_____
Legal Custodial Parent, guardian