

**MidStep Centers for Child Development**  
454 Rolling Ridge Drive, State College, Pennsylvania 16801  
Phone: (814) 235-1100 Fax: (814) 235-1101 Website: [www.midstep.com](http://www.midstep.com)

**CONSENT FORM**

For Psychological Services provided Dr. Carol L. Skinner regarding:

\_\_\_\_\_  
(Print Patient's Name) (Date of Birth)

I have received and read the *Services Agreement* and the *Privacy Notice* from Dr. Skinner.

I agree to participate in psychological services with Dr. Skinner while abiding by the terms and conditions described in the *Services Agreement* and the *Privacy Notice*.

This consent is valid for the duration of services, unless otherwise agreed to in writing.

\_\_\_\_\_  
Signature of Parent/Guardian Relation to Patient Date

\_\_\_\_\_  
Signature of Parent/Guardian Relation to Patient Date

\_\_\_\_\_  
Signature of Patient (14 years and older) Date

**WAIVER OF RIGHTS TO ACCESS ADOLESCENT'S TREATMENT RECORDS**

In the interests of promoting privacy and efficacy for my child in psychotherapy, I consent to waive my rights to access to my child's mental health treatment records, except for summary information that may be provided at Dr. Skinner's discretion.

\_\_\_\_\_  
Signature of Parent/Guardian Relation to Patient Date

\_\_\_\_\_  
Signature of Parent/Guardian Relation to Patient Date