Pediatric Psychological Associates PLLC

Child's Name: ______________________________

DOB: ____________________________________

Parental Consent/Permission Form
Pediatric Psychological Associates, PLLC

I authorize permission for my child to receive psychological services from Tessa Breedlove, Psy.D. , a Postdoctoral Fellow, at Pediatric Psychological Associates. In compliance with state regulations, Dr. Breedlove is currently being supervised by Kelly McGraw Browning, Psy.D., Licensed Clinical Psychologist. As such, Dr. Browning will have access to my child's pertinent records and information discussed in therapy sessions.

The purpose of this supervision is to enhance the professional development and to ensure quality services for my child.

If I should at any time desire to speak and/or meet with Dr. Browning, she may be reached at (502) 429-5431.

By signing below, I indicate that I understand and agree to the above condition.

______________________________ ____________
Signature of Parent/Guardian Date

______________________________ ____________
Signature of Parent/Guardian Date

9700 Park Plaza Avenue, Suite 106 · Louisville, Kentucky 40241 · Phone: 502-429-kid1(5431) · Fax: 502-429-5439
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