
**Nicole Ann Cavenagh, PhD**
**Licensed Psychologist/Pediatric Neuropsychologist**

## Legal Guardianship

Patient Name:_____

Patient Date of Birth:_____

I, the undersigned, indicate by my signature below that I have legal custody/legal guardianship of my child (named above), and, therefore, the right to seek evaluation and/or treatment for my child. I have been advised by Nicole Ann Cavenagh, PhD, that it is their recommendation that my child's other parent, if any, be informed of my decision to seek evaluation and/or treatment.

_____ _____
Printed Name – Parent or Legal Guardian Date

_____ _____
Signature Date

_____ _____
Signature of Staff Witness Date