**Marilyn J. Wooley, Ph.D.**

**Clinical Psychologist**

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***Postdoctoral Intern:* Dave Nervo, PSY.D. PSB94024001 (530) 917-0947**

***Practicum Student:* Shaneika Smith, MA (530) 710-5251**

**CONSENT FOR TREATMENT WITH A POSTDOCTORAL INTERN**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize and request that Jessica Buick, Ph.D. and/or Leslie Gabriele, Ph.D., unlicensed interns under the direct supervision and employment of Marilyn J. Wooley, Ph.D., Licensed Clinical Psychologist, carry out psychological examinations, clinical treatments, and/or diagnostic procedures which now or during the course of my care as a patient are advisable.**

**I understand that the purpose of these procedures will be explained to me and be subject to my agreement.**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby give my written consent to have**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*name of intern*), an unlicensed intern, disclose any**

**medical, psychological or personal information concerning me to Marilyn J. Wooley, Ph.D.**

**This authorization expires on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. It may be revoked at any time by written notification to Marilyn J. Wooley, Ph.D.**

**I have read and fully understand this Consent for Treatment Form.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Signature Date**