



**Toronto Psychological Services
& Research Centre**

AUTHORIZATION FOR CONSULTATION

Client's Identifying Information

Client's Full Name: _____

Date of Birth *Month dd yyyy*: _____

For Clients Requesting That TPS Consults on Their Behalf

I hereby authorize TPSRC to disclose information about my Psychological Assessment. I also agree to pay the associated Consultation Fee in advance (Minimum of \$300 per 45-50 minutes for an In Person, Telephone or Video Session).

School Personnel, Medical Personnel/Healthcare Provider, Legal Personnel, or Other

Organization Name: _____

Full Legal Name *Primary Contact*: _____

Honorific Title: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ None ☐ Other *Specify* _____

Preferred Pronouns: ☐ She/Her ☐ He/Him. ☐ They/Them ☐ Other *Specify* _____

Relationship to Client: ☐ Doctor ☐ Lawyer ☐ Teacher ☐ SERT ☐ Other *Specify* _____

Telephone Number and Ext.: _____

Email Address: _____

Fax Number: _____

Authorized Signatories

I, the undersigned client (or legal guardian if client is younger than 18 years), authorize Toronto Psychological Services & Research Centre to communicate with the named Contact to facilitate the current Psychological Assessment Process.

Signee's Information:

Full Name: _____

Client (18+) / Parent or Legal Guardian Signature _____

TPSRC Representative:

Dr. Ghia Townsend, Psy.D., C. Psych.

Member of the College of Psychologists and Behaviour Analysts of Ontario

Registration #6361
