

Floyd Covey, D.D.; Th. D.; Ph. D.; C. Carm. of C.T.P.; O.SS.T.
Bishop / Priest / Psychologist / Monk
Counseling from a Christian View
Soul Care and Wisdom Guidance

AUTHORIZATION TO PROVIDE PSYCHOLOGICAL CARE TO MINORS

I certify that I, _____ am the custodial parent or
legal custodial guardian of _____, who is a minor or
dependent under the laws of the State of Tennessee.

I, _____, request and authorize Dr. Floyd Covey to
provide psychological care to _____. Such care may
include, but is not limited to, personal interviews, therapy sessions, psychological tests,
and other generally accepted practices in the field of psychology.

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Name of Patient: _____

Signature of Patient: _____ Date: _____

Name of Guardian (If Patient is a Minor): _____

Relationship of Guardian to Patient: _____

Signature of Guardian: _____ Date: _____