



**HUDSPETH REGIONAL CENTER  
DIAGNOSTIC SERVICES DEPARTMENT**

**CONSENT FOR EVALUATION FORM**

I hereby authorize that \_\_\_\_\_ may be evaluated by the Diagnostic Services Department at Hudspeth Regional Center using professional staff, consultants, interns, practicum students, or other evaluators designated by and deemed appropriate by the facility. I understand that the evaluation may include an assessment of any or all of the following as deemed appropriate: intellectual/cognitive abilities, adaptive behavior, maladaptive behavior, achievement, communication, vision, and hearing. I also understand that portions of the evaluation may rely on informant report.

I understand this evaluation may be observed by staff and practicum students from other departments at Hudspeth Center and by other persons deemed appropriate by the facility.

\_\_\_\_\_  
Person (if 18 years of age and ruled independent)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Responsible party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date