



PSYCHOLOGICAL CENTER  
for Expert Evaluations, Inc.

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**Collateral Contact Statement of Understanding**

Collateral Contact Name: \_\_\_\_\_

Evaluator Name: \_\_\_\_\_

Regarding Case: \_\_\_\_\_

Child Custody evaluators strive to use multiple data gathering methods that are as diverse as possible and that tap divergent sources of data, thereby facilitating the exploration of alternative plausible hypothesis that are central to the case. Considering this, you have been identified as an individual who may have first hand information relating to the case at hand. Should you agree to participate in a information gathering session with the evaluator, you must understand the information will likely be used in court, in discovery, by record, or if the evaluator testifies. All sources of information which include phone calls, letters, emails, and all other forms of communications are included.

**This information may be communicated in written and/or oral form.** I understand that authorizing the disclosure of this information is voluntary and I can refuse to sign this authorization. I acknowledge by my signature that I understand that this consent remains in effect for six months or until revoked in writing by the patient. A photocopy or fax of this authorization will be treated in the same manner as the original.

Please ask any questions or raise any concerns to your evaluators prior to signing this statement of understanding.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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