

Authorization for Treatment of a Dependent Minor

name of parent or legal guardian

hereby authorizes James Robert Ross, Ph.D., LMFT, 275 Malabu Drive, Lexington, KY 40502 to provide mental health treatment for:

DOB ____/____/____

Name of minor child to be treated

This consent is valid until completion of treatment or until _____
whichever comes first.

I understand that I may revoke this consent, either orally or in writing, at any time.

Signature of parent or guardian

Witness

date

CLN\Auth for Tx.wpd

Please complete this form and return with signatures to Anchor Counseling, 275 Malabu Drive, Lexington, KY 40502.