AUTHORIZATION TO TREAT MINOR CHILD

Center for Family Healing

By signing below, I affirm that I am the legal guardian/parent of the following listed child/children and consent to treatment in psychotherapy. I also agree to notify the other legal guardian/parent of treatment and assume sole responsibility for arranging payments for all services provided. I acknowledge that I may remove my child/children from therapy at any time and have been notified of mandated reporting laws for Kansas.

_____	_____
Name of Child	Date of Birth
_____	_____
Name of Child	Date of Birth
_____	_____
Name of Child	Date of Birth
_____	_____
Name of Child	Date of Birth

_____	_____
Signature of Parent/Legal Guardian	Date