RELEASE FOR THE TREATMENT OF A MINOR

As the parent or legal guardian of ____________________________________ D.O.B.:__________ I authorize his/her evaluation and treatment. As parent or legal guardian, I have the right to request information concerning the above minor's evaluation treatment. I understand that I have the right to revoke my consent for treatment at any time. Such revocation must be received in writing by Dr. Kimberly Rubin Ph.D. to take effect.

_______________________________________ _______________

Signature of Client, Parent or Guardian Date

_______________________________________ _______________

Signature of Client, Parent or Guardian Date

_______________________________________ _______________

Witness Date

199 North Main Street, Suite 105 ◆ Plymouth, Michigan 48170 ◆ 248-387-9495