WHITE HOUSE CLINICS

Authorization for Treatment of an Adult Under State Guardianship

Patient Name:_____

Patient DOB:_____

My signature below attests that I am consenting to the following treatment for _____:
Name of Patient

Description of Treatment:_____

_____

_____

This consent is only effective for treatment on _____.
Date

NOTE: Please immediately fax this form back to the following facsimile number after signature:

Facsimile No.:_____

_____ _____
Printed Name of Social Worker **Date**

_____
Signature of Social Worker

DCBS Office Telephone & Fax Numbers:

Estill County:
606-723-5146 (Telephone)
606-723-3246 (Fax)

Jackson County:
606-287-7114 (Telephone)
606-287-4475 (Fax)

Madison County (Berea Office):
859-986-8411 (Telephone)
859-986-4443 (Fax)

Madison County (Richmond office):
859-626-5833 (Telephone)
859-623-1925 (Fax)

Rockcastle County:
606-256-2138 (Telephone)
606-256-2188 (Fax)

For Internal Use Only:
Form unable to be faxed; verbal consent was obtained.

_____ _____
Employee Signature Date

_____ _____
Employee Signature Date