AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS AND INFORMATION

Kenneth Roberson, Ph.D.

RESET FORM

I hereby authorize

Person or Facility:

Address:

Phone:

Email:

To Exchange Information About:

WITH

Person or Facility: **Kenneth Roberson, Ph.D**

Address: **2021 Fillmore Street, PMB2187**

Phone: **415-922-1122**

For the Following Purpose(S):

- [X] Further Mental Health Evaluation, Treatment, or Care
- [ ] Treatment Planning
- [ ] Other

The information to be disclosed is marked by an X in the boxes below:

- [ ] Medical History and Evaluation(s)
- [ ] Mental Health Evaluations
- [ ] Progress Notes, And Treatment or Closing Summary
- [X] Other
- [ ] Personal Observations

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken.

SIGNATURE OF PATIENT | PRINTED NAME | DATE