

AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS AND INFORMATION

Kenneth Roberson, Ph.D.

I hereby authorize

Person or Facility:

Address:

Phone:

Email:

To Exchange Information About:

WITH

Person or Facility:

Address:

Phone:

For the Following Purpose(S):

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

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