

# KENNETH ROBERSON, PH.D

CALIFORNIA LICENSE PSY11958

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## CHILD CONSENT FORM & AUTHORIZATION FOR RELEASE OF INFORMATION

TO: \_\_\_\_\_  
Physician, Psychotherapist, or Other Health Care Provider

STREET: \_\_\_\_\_

CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

I, \_\_\_\_\_ (*your name*), authorize

Physician, Psychotherapist, or Other Health Care Provider \_\_\_\_\_

\_\_\_\_\_ (*as above*) to give and receive information

concerning my child's physical and emotional health to Kenneth Roberson, Ph.D. via  
phone, fax, email or USPS.

This authorization remains in effect throughout my child's care with Dr. Roberson or until  
discontinued by me.

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness' Signature

\_\_\_\_\_  
Date

Please mail or fax this completed form to:  
1700 Pierce Street, Suite 402, San Francisco, CA 94115  
Fax: 415-440-7436

Or, please email scanned copy of completed form to:  
info@kennethrobersonphd.com