Elizabeth Roberts, PsyD
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CONSENT FOR TREATMENT

I give consent for my child to receive psychological and/or neuropsychological services from Dr. Elizabeth Roberts.

I understand that services are provided on a confidential basis and records are disclosed only when properly authorized.

Signature of parent or guardian _____ Date _____

If signed by a guardian, please describe legal basis for guardian status _____

_____

Receipt of HIPAA Disclosure Form, Notice of Privacy Practices, and Client Agreement from Elizabeth Roberts

I acknowledge that I have received copies of any HIPAA Disclosure forms I have signed to facilitate my child's are with Dr. Roberts as well as my signed Notice of Privacy Practices and the Client Agreement

Signature of Parent or Guardian _____ Date _____

Print Your Name _____