PATIENT CONTACT SHEET

HIPPA

I hereby authorize and give consent to Bonnie L. Atkinson, Ph.D., L.L.C. to leave voice messages at the following :

HOME YES/NO WORK YES/NO CELL YES/NO

Regarding:

____Appointment Reminders _____Test Results

____ Psychological Emergency Calls

I hereby authorize and give my consent to Bonnie L. Atkinson, Ph.D., L.L.C. to communicate any of my Protected Health Information to the following person(s):

Name Relationship

____

____

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Patient/Parent Signature: __________________________ Date:_________