HEART | MIND
THERAPY

EMERGENCY CONTACT

Client Name: DOB: / /

I authorize ***Dr. Jana Corbett*** to ☐ obtain information from and ☐ disclose information to

Name:
Organization:
Address:
Phone number:
Fax:
E-Mail address:

With my signature below, I authorize Dr. Jana Corbett to contact the person listed below

- ☐ in the case of a medical or mental health emergency
- ☐ to coordinate care.

I understand that the purpose of this authorization is to facilitate communication in the case of emergency and to coordinate care with a person of my choice. I understand that I am not required to sign this authorization. If I decline to sign this authorization, it will not prevent me from getting care. I understand that I may revoke this authorization in writing at any time. This authorization expires 60 days after the completion of treatment or closing of the client file respectively.

I have read this authorization and understand it. (You may sign electronically through the patient portal.)

Client signature:______________________________ Date: ____________________