AUTHORIZATION TO LEAVE MESSAGES AND SEND WRITTEN CONSENTS

In the event in which Dr. Lisa Schwellinger must telephone the client for purposes such as an appointment, cancellation or reminder, or to give/receive other information, efforts are made to preserve confidentiality. Please list where Dr. Schwellinger may reach you by phone and how you would like her to identify the services.

I, _____, authorize Dr. Lisa Schwellinger to leave messages for me at:

____ Home: ( )_____	Can I identify myself?:	____ Yes ___ No
	Can I state purpose of call?:	____ Yes ___ No
_____Work: ( ) _____	Can I identify myself?:	____ Yes ___ No
	Can I state purpose of call?:	____ Yes ___ No
_____Other: ( ) _____	Can I identify myself?:	____ Yes ___ No
	Can I state purpose of call?:	____ Yes ___ No

I authorize Dr. Schwellinger to send letters and other written communications to my home address.
_____ Yes _____ No

I authorize Dr. Schwellinger to speak or send written communications to the following individuals:

Individual: _____ Relationship to Client: _____

Individual: _____ Relationship to Client: _____

Individual: _____ Relationship to Client: _____

Individual: _____ Relationship to Client: _____

_____

Client's Signature Date:

_____

Psychologist's Signature Date