COMMUNICATION CONSENT
Lehigh Psychological Services

It is the policy of Lehigh Psychological Services and our staff not to leave confidential and/or unauthorized information (such as evaluation results) on an answering machine, voice mail, cell phone and/or pager message system, or with an unauthorized person who may answer your telephone. Please advise us if there are any telephone numbers at which we may not return calls or leave messages.

I authorize Lehigh Psychological Services and/or their staff to leave information pertaining to my care by the following methods and will assume responsibility to notify Lehigh Psychological Services whenever this information changes.

May Call Home Telephone	_____yes	_____no
May Leave Message on Home Answering Machine or Voice Mail	_____yes	_____no
May Call Work Telephone	_____yes	_____no
May Leave Message on Work Answering Machine or Voice Mail	_____yes	_____no
May Call Cell Phone and/or Pager	_____yes	_____no
May Leave Message on Cell Phone or Pager	_____yes	_____no

If you would like to have information released to someone other than yourself about appointment scheduling, insurance or billing questions, please complete the following. *Please note that to release clinical information regarding your care to a friend or family member, you will have to sign a separate Authorization for Release of Information specifically stating what kinds of information may be shared.*

Please list names of authorized people:

Spouse: _____ _____yes _____no

Parent: _____ _____yes _____no

Other names *(please list relationship such as friend, sister, etc.)*

Name _____ Relation: _____ _____yes _____no

Name _____ Relation: _____ _____yes _____no

Name _____ Relation: _____ _____yes _____no

****PRINTED NAME**_____ Date: _____

Client Signature (or parent/guardian) _____