Emergency Contact Information

Patient Name: _______________________________DOB:________________ Age:_________

Person to contact in the event of an emergency:_______________________________________

Relationship:____

Home Phone: ____________________ Cell:__________________ Other:_________________

By signing below I give permission for affiliates of Houston Psychotherapists, Inc. to contact the above individual and discuss my situation in the event of a medical and/or psychiatric emergency.

Signature of Patient: _______________________________ Date: _______________________

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