



Counseling and Wellness Center of South Florida

11011 Sheridan Street, Suite 211
Cooper City, Florida 33026
Office-(954) 951-2929 Fax-(954) 252-3767
www.cwcsf.com

Consent to Contact

With my consent, CWCSF may call my home, cell, or other designated location and may leave a message on voice mail or in person that assists the practice in carrying out normal office procedures, such as appointment reminders or any needed information pertaining to my clinical care.

With my consent, CWCSF may text my cell other designated location that assists the practice in carrying out normal office procedures, such as appointment reminders or any needed information pertaining to my clinical care. Text reminders may come from a HIPAA compliant system.

With my consent, CWCSF may email me at my home or other designated location any item that assists the practice in carrying out normal office procedures, such as appointment reminders, client statements, or any needed information pertaining to my clinical care.

With my consent, CWCSF may mail to my home or other designated location any item that assists the practice in carrying out normal office procedures, such as appointment reminders, client statements, or any needed information pertaining to my clinical care.

Communication via Social Media is strictly prohibited by law. However, the practice is not required to agree to the requested restrictions, but if it does, it is bound by this agreement.

I agree to allow CWCSF to contact my emergency contact on my behalf in the case of emergency

By signing this form, I am consenting to CWCSF to use and disclosure of my client information in order to carry out normal office procedures as well as emergency situations.

I may revoke my consent in writing except to the extent that the practice has already made such disclosure in reliance upon my prior consent. If I do not sign this consent, a CWCSF therapist may decline to provide treatment to me.



(Signature)

(Date)

(Signature)

(Date)

(Print Name)

(Print Name)