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Privacy Notice

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide Bonnie Connor, Ph.D., Licensed Psychologist PSY 22446, with my authorization and consent to use and disclose my protected health care information (PHI) for the purposes of treatment, payment, and health care operations as described in the Privacy Notice.

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200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, D.C. 20201

Patient's Name (print)

Patient's or Guardian's Signature

Date

Bonnie Connor, PhD Signature

Date