Bonnie Connor, PhD
PSY 22446
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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.

If you have a complaint and are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
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

Submit