Emergency & Other Contacts

Please provide an emergency contact and, if helpful, other professionals involved in your care.

Client Information

Full name

Preferred name

Date of birth (MM/DD/YYYY)

Emergency Contact

Contact name

Relationship

Primary phone

Alternate phone

Email

Notes or Contact Preferences (Optional)

Please describe what may or may not be discussed with this person and any other contact preferences.

I authorize Robert Romano, LCSW, LLC to contact this person in an emergency or when reasonably necessary to support my safety. This authorization does not permit routine disclosure of my psychotherapy records.

☐ I authorize contact with this person as described above.

Emergency & Other Contacts

continued

Additional Emergency Contact (Optional)

Contact name

Relationship

Primary phone

Alternate phone

Email

Notes or Contact Preferences (Optional)

Please describe what may or may not be discussed with this person and any other contact preferences.

I authorize Robert Romano, LCSW, LLC to contact this person in an emergency or when reasonably necessary to support my safety. This authorization does not permit routine disclosure of my psychotherapy records.

☐ I authorize contact with this person as described above.

Other Professional Involved in Your Care (Optional)

Name

Role / specialty

Organization

Phone

Email

Listing a professional here does not authorize the release of records or ongoing communication. A separate written authorization may be required before information is shared.

Client name (printed)

Date

Client signature