CITYVIEW PSYCHIATRY, P.A.
Debra Atkisson M.D, P.A.
6320 Southwest Blvd. Suite 207
Fort Worth, TX 76109
817.735.4430 Fax 817.735.4565

Patient Name: _____

Responsible: _____

I, _____, have reviewed, understand and agree to abide by the
(Print full name here)
Policies and procedures outlined by the practice of Dr. Debra Atkisson. I have also had the opportunity to review the HIPAA policies and understand my rights. A copy is available to me on request or on the practices website.

_____
Signature of responsible party

_____
Date