Rob Womack, M.Div; LPC
1200 Broad St, Suite 103
Durham, NC 27705
Ph: 919-682-6549
rob@robwomackcounseling.com

AUTHORIZATION FOR THE RELEASE AND EXCHANGE OF INFORMATION

I, _____, hereby authorize_____ to share the specified information in my client record with my mental health counselor Rob Womack, M.Div; LPCA. Unless otherwise stated, this release is reciprocal, meaning that Rob Womack may share the below specified information with the party named above.

This information shall include (initial each applicable item):

Psychological Evaluation_____ Psychiatric Evaluation_____

Screening/Admission Information_____ Diagnostic Information_____

Service Plan_____ Substance Abuse Diagnosis and Treatment_____

Medical Information_____ School Records (conduct, academic)_____

Summary of Treatment_____ Discharge Summary

Other_____

Limitations on this release of information:

_____

_____

_____

The purpose of the disclosure is to

☐ Assist with treatment
☐ Assist with a Referral
☐ At the Request of Client
☐ Other:

I have not been coerced to sign this release and I understand that my treatment is not conditional on my signing. I understand that I can revoke this authorization at any time. If not revoked earlier, this authorization expires automatically on _____ or one year from the date it is signed, whichever is earlier.

_____
Client (or legally responsible party) Signature and date

_____
Client's Full name and date of Birth