

Rob Womack, Telehealth Therapist  
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I, , give my consent to Rob Womack to be in communication with

YOUR NAME

at .

THEIR NAME

EMAIL, PHONE #, OR ADDRESS

He is to use his discretion to discuss topics marked below. This consent to communicate will be in effect for 90 days after our most recent contact; meaning, unless rescinded in writing, it will remain in effect as long as we are engaged in an ongoing professional relationship. I understand that I can rescind this permission with a written statement by email or letter at any time.

☐ Convey to my employer a basic understanding of my situation and requested accommodations

☐ Convey to my family a basic understanding of my situation and requested accommodations

☐ Convey to my school a basic understanding of my situation and requested accommodations

☐ Coordinate care with my physician for the management of medications and other treatments

Other

Specific limitations to which I would like them to adhere to discuss only what is listed here:

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Your Signature & Today's Date:

Your Printed Name & Date of Birth:

Preferred third person pronouns (they/them; she/her; he/him):