Rob Womack, Telehealth Therapist
2513 Vesson Avenue
Durham, NC 27707
Phone: 919 682 6549
Fax: N/A
email: womackrp@gmail.com
Website: equalsheal.com

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 This consent to communicate will be in effect for 90 days after our most recent contact; meaning, unless rescinded in writing, it will remain in effect as long as we are engaged in an ongoing professional relationship.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:

_____

_____

Your Signature: _____

Today's date: _____

Your Printed Name & Date of Birth: _____