**Night Owl Counseling: Debbie Webb, Ph.D., LCSW-S, LPC, LCDC**

Mailing Address: 2407 S. Congress Ave., Ste. E-730, Austin, Texas 78704-5500

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**Consent Form for Dr. Debbie Webb to Speak with/Release Client Information / Record**

|  |  |
| --- | --- |
| Client Name: | Member Code (in office use): |
| Date of Birth: | Soc Sec#: Last 4 digits: |

ALL items must be checked either “YES” or “NO;” do not leave any blanks.

This authorizes Dr. Debbie Webb to release information to other person(s) or agencies named below:

|  |
| --- |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Disclosed information limited to: Specific Limitations:

|  |  |
| --- | --- |
| Yes\_\_\_\_ No\_\_\_\_ Assessments  Yes\_\_\_\_ No\_\_\_\_ Care Plan or Care Plan Updates  Yes\_\_\_\_ No\_\_\_\_ Progress Notes  Yes\_\_\_\_ No\_\_\_\_ Statement/Invoice Information  Yes\_\_\_\_ No\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

Purpose/Need for disclosure:

|  |
| --- |
| Yes\_\_\_\_ No\_\_\_\_ Coordinate concurrent services/evaluate treatment  Yes\_\_\_\_ No\_\_\_\_ Treatment  Yes\_\_\_\_ No\_\_\_\_ Continuity of care  Yes\_\_\_\_ No\_\_\_\_ To facilitate insurance benefits  Yes\_\_\_\_ No\_\_\_\_ Determine eligibility for disability benefits  Yes\_\_\_\_ No\_\_\_\_ Assist in Legal matters  Yes\_\_\_\_ No\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

This consent to disclosure may be revoked at any time, but the revocation will not affect any action already been taken in accordance with the consent. This consent, unless revoked sooner, will expire one (1) year from the date of signature.

|  |  |
| --- | --- |
| Client signature: | Date: |
| Family/Legal Guardian signature: | Date: |
| Witness signature: | Date: |

02/27/2023