momentum
mental health

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Consent to Contact

The purpose of this form is to give Robin C. Darbonne, M.A., LPC permission to contact or be contacted by health and/or educational professonals on the client's behalf. This may or may not include conversations related to client's confidential information.

Client's Name: _____ DOB: ____/____/____

Your relationship to client: ☐ Self ☐ Parent/Legal Guardian
☐ Legal Representative ☐ Other: _____

Check All That Apply:

☐ I give Robin Darbonne, M.A., LPC consent to contact or be contacted by the following people:

Name: _____ Title: _____

Phone: _____

Name: _____ Title: _____

Phone: _____

☐ I have read and signed a professional disclosure statement and privacy form provided by Robin Darbonne, M.A., LPC, Momentum Mental Health LLC.

I realize that although every precaution will be taken, the above means of communication may not be completely confidential and I authorize the above request(s).

Client's Signature _____ Date: __/__/__

Parent/Guardian/Representative Signature: _____ Date: __/__/__

Therapist's Signature: _____ Date: __/__/__