Debbie Urban, MEd, NCC, LPC
RR2 Box 26221 Pine Cone Lane
Piedmont, MO 63957
(573) 727-6428 or (314) 304-2942
Fax: (573) 223-7363

RELEASE

Client:_____DOB:_____

I, _____, give permission for Debbie Urban to receive/provide verbal and written information to/from:

_____
_____
_____

for the purposes of providing therapy and the continuum of care for the above Client.

Please send/provide information (check):
☐ Initial Assessment
☐ Treatment Plan
☐ Progress Report
☐ Medications prescribed
☐ Discharge Summary
☐ Other:_____

I understand that I can revoke this at any time by written request and that is will cease to be in effect upon my discharge from the care of Debbie Urban.

Signatures:

Client or Guardian:_____

Witness:_____

Date:_____