Chris Jones Therapy

Consent to release information

Client Information

Full name: .....
DOB: .....
Home address:

.....

.....

I, ... (Insert your name), authorize the sharing of information between the two parties named below.

Party number 1:	Party number 2
Chris Jones MBACP, DSTT	
Chris Jones Therapy	

I provide this consent with the sole aim of supporting and furthering my own therapeutic goals. I understand that I have the right to decline this permission. I also understand that I have the right to revoke this permission at any time, by providing written notice. I understand that revocation of this agreement will not cover any information shared between these parties up to that time.

Client signature: .....

Client name: .....