



Chris Jones Therapy  
Consent to speak to partner

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:

Chris Jones MBACP, DSTT

Chris Jones Therapy

Party number 2 (Partner)

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: .....