Integrative Psychology Group, LLC.

A cooperative practice with an integrative approach to growth and healing.

300 Creek View Road, St 101
Newark, DE 19711

Phone (302) 307-3702 Fax (302) 355-3400

EXCHANGE OF CONFIDENTIAL INFORMATION

Date:_____

I_____(client/guardian) give consent for _____ to exchange necessary information with_____ limited to the degree necessary for_____

_____.

This release is good for the dates _____ to _____. I understand that I can revoke this consent at any time.

Client: _____ Date _____
(please print name of client)

Signed:_____ Date:_____
(Client/Guardian)

Signed_____Date:_____
(Clinician)

(I understand that the law allows for exchange of information between two heath care professionals without my written consent if I am in treatment with both, for the purpose of coordinating my care).