

REFLECTION PSYCHOLOGY

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Consent to exchange information.

I, _____ (Name)

of _____ (Address)

Hereby authorise staff employed at Reflection Psychology to:

Provide information regarding the scheduling of my appointments and payment of appointments with

_____ (Name)

Signature: _____
(Signature, initials or full name accepted)

Date: _____

Melbourne CBD
Block Arcade Level 2,
Suite 201, 282-284 Collins St
Melbourne 3000

Fairfield
Alphington Medical
29-31 Station St
Fairfield 3078

McKinnon
158 McKinnon Rd
McKinnon 3204

Camberwell
520 Camberwell Rd
Camberwell 3124

