

# ADE, Inc

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I give permission to Martha Ireland, PhD, R.N., C.S., C.E.D.S., to share my communications with her, pertaining to my family member(s), and myself to other significant family members and other independent treatment team members on a need to know basis. Dr. Ireland has the sole discretion to disclose or not to disclose shared information with the above parties. Dr. Ireland will decide based on what is most appropriate for the therapeutic process.

Date.....

Print name.....

Signature.....

If the client is minor then the legal guardian or parent must sign for the minor client:

Print Name.....  
(parent or legal guardian)

Signature.....  
(parent or legal guardian)

