

AUTHORIZATION FOR RELEASE OF INFORMATION

Argosy University, Chicago
American School of Professional Psychology
225 N. Michigan Ave., Chicago, IL 60601
Phone: 312-777-7665 Fax 312-777-7747

I, the undersigned, _____ (Name of Client in Print), authorize

_____ (Name of Graduate Student) at _____

_____ (Name of Training Site) to use information, including but not limited to, case

material and audio/video taping, that s/he obtains regarding my assessment or treatment for educational purposes only at the Illinois School of Professional Psychology, Argosy University Chicago Campus. By signing this form, I understand that:

1. All identifying information in the tapes will be kept confidential.
2. The professional group will be advised that in the unlikely circumstance that they recognize the identity of the person in the case, they should immediately excuse themselves from the room. Further, they are bound by confidentiality not to reveal what they have heard.
3. I may review this information upon request.
4. This consent is valid for twelve (12) months. However, I may revoke my consent at any time within this twelve-month period.
5. Refusal to consent to release of my information will not affect my rights to receive treatment.
6. At the end of the training year, the graduate student named above will destroy all the video/audio tapes by using tape erasers provided by the University Training Department.

My signature below confirms that the above named Graduate Student has explained to me the above policies regarding the use of my information for educational purposes.

Client Signature

Date

If the client is a minor, the custodial parent/legal guardian must sign this consent form. If the client is at least 12 years of age, but under 18, the client must sign in addition to his/her parent/legal guardian.

Parent/ Guardian Signature

Parent/Guardian Name in Print

Date

Graduate Student Signature

Date

e-mail to: gkoch@argosy.edu