Emory University Psychoanalytic Institute
Tufts House, Suite 302
2004 Ridgewood Drive
Atlanta, GA 30322
404.727.5886 (fax) 404.727.0508

PATIENT INFORMED CONSENT FOR TREATMENT

I have applied for a personal psychoanalysis or psychoanalytic psychotherapy with a candidate who is enrolled in a formal educational program at the Emory University Psychoanalytic Institute and who has been approved by the Institute to conduct psychoanalysis or psychoanalytic psychotherapy under the supervision of a licensed clinician and faculty member of the Institute.

I understand that my treatment will be discussed with a supervisor on a regular basis for clinical and educational purposes. I consent to the written recording of treatment sessions for that purpose. I understand that, in addition, those written recordings and reports about the treatment may be used in teaching, research, and certification. I agree to the use of those written materials for these stated purposes, with the understanding that my provider and the Institute will exercise the utmost care in protecting the anonymity and confidentiality of those records, consistent with those purposes.

I understand that my participation in the psychoanalysis or psychoanalytic psychotherapy is voluntary and that I may choose to withdraw at any time by so informing my provider.

_____
Name (please print)

_____
Signature

_____
Date

_____
Witness

_____
Date