

**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 PSYCHOANALYTIC PSYCHOTHERAPY

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

I understand that my psychotherapy will be discussed with a supervisor on a regular basis for clinical and educational purposes. I consent to the written recording of treatment sessions with my psychotherapist for that purpose. I understand that, in addition, those written recordings and reports about the psychotherapy 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 psychotherapist 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 psychotherapy is voluntary and that I may choose to withdraw at any time by so informing my psychotherapist.

Name (please print)

Signature

Date

Witness

Date