IPCI
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Consent for Treatment by a Post-Doctoral Clinician Under Licensed Psychologist Supervision

After completion of a doctoral program in psychology, but before a doctoral-level psychology provider can practice independently, without supervision from a licensed psychologist, clinicians must receive supervision from a psychologist with a Health Service Provider of Psychology (HSPP) designation until the clinician receives their own HSPP designation. Clinicians under supervision routinely collect information regarding patients to ensure that they are providing the best possible treatment. With patient consent, information regarding your treatment would be shared with the clinician's clinical supervisor. This may include discussion employing notes taken during or after our session; psychological test responses, scores, and interpretations; video-recordings, audio-recordings, or written transcripts of our sessions; or other materials such as historical data, questionnaire responses, information from your record.

Audio- and video-recordings cannot be altered for purposes of clinical supervision. Such materials will only be shown to or played for the clinician's supervisor, who is also bound by state laws and/or professional rules about patients' privacy. These materials will be maintained in a secure location and will be destroyed as soon as they are no longer needed.

Your clinician's direct clinical supervisor is Maria P. Hanzlik, PsyD, HSPP, clinical psychologist. The clinician meets with Dr. Hanzlik to review clinical case material on a weekly basis, but the clinician will be the one with whom patients have direct contact regarding all points of clinical care.

Please read and sign the following:

I give the clinician, Josie Gronbach, PsyD., my permission to use information regarding my treatment for educational and professional purposes. All individuals with whom this information is shared are bound by state laws and/or by professional ethics rules about patients' privacy. I give my consent to have clinical material and information related to my treatment used for clinical supervision. The purpose and values of using this information have been fully explained to me, and I freely and willingly consent to its use.

_____ _____
Signature of Patient/Guardian Date

_____
Printed name of Patient

_____
Relationship to Patient

_____ _____
Signature of Clinician Date

_____
Printed Name of Clinician