

## Consent for Evaluation

Welcome to the Department of Psychology at Georgia State University (GSU). The Department has two separate centers, which share an office suite on the 10<sup>th</sup> floor of the Urban Life Building: the Psychology Clinic for Assessment, Therapy, and Research; and the Regents Center for Learning Disorders (Suite 1053). During the time that you receive clinical services within the GSU Department of Psychology, you may encounter personnel from both centers in this shared physical space. All personnel of these two centers, which include staff and clinicians, are part of the GSU Department of Psychology. Thus, all personnel adhere to the American Psychological Association's ethical standards including confidentiality guidelines. If you have any questions concerning this, please talk to your assigned clinician.

You may be aware that Georgia House Bill 280, often referred to as the "Campus Carry" law, went into effect on 7/1/2017. The Campus Carry legislation allows anyone properly licensed in the state of Georgia to carry a handgun in a concealed manner on university property with noted exceptions. One of the noted exceptions is within faculty offices and office suites. Suite 1053, which houses the Psychology Clinic and the Regents Center for Learning Disorders, is an office suite, and handguns are not allowed within this area. Information about the law can be found at [safety.gsu.edu/campus-carry](http://safety.gsu.edu/campus-carry). It is the responsibility of the license holder to know the law. Failure to do so may result in a misdemeanor charge and may violate the Georgia State Student Code of Conduct.

I, in signing this form, and **INITIALING** each appropriate blank below, signify my understanding that:

I have completed the information contained in this packet to the best of my ability and agree for it to be released to the Regents Center for Learning Disorders (RCLD) at Georgia State University.

I have been informed of the cost involved in obtaining this evaluation and agree to make payment or arrange for payment by the date of my first appointment.

I understand that the information contained in this packet and all other information provided over the course of this evaluation will be used as part of a diagnostic evaluation of my intellectual, psychological and learning abilities. I understand that the purpose of this evaluation is to identify any developmental, psychological, or psychiatric disorders that could impact my academic functioning, and to make recommendations regarding appropriate academic accommodations and/or interventions.

I understand that the information contained in this packet and all other information provided over the course of this evaluation is confidential, and that the RCLD will keep confidential all information gathered during this evaluation and will not release or discuss the results of my evaluation with any other persons outside the Center without my written permission, with the following four exceptions: 1) if there is reason to believe that I am at imminent risk for doing serious harm to myself, 2) if there is reason to believe that I am at possible risk for doing serious harm to others, 3) if there is reason to believe that a child under the age of eighteen or a vulnerable adult has been abused, neglected or exploited, and, 4) if disclosure of information is ordered by a judge in a court of law.

I understand that there may be privacy issues involved in completing my evaluation. The RCLD is sensitive to privacy needs, and works to maintain a comfortable setting for all clients. Please be aware that there may be times when you encounter someone in the RCLD whom you know from another setting. For example, if you are a student at GSU, you may happen to see your instructor, professor, or a fellow student. You might also encounter your clinician or someone else from the RCLD in another setting. If either of these situations occurs or you are concerned about such potential encounters, discuss this with your assigned clinician to determine if this situation poses a significant conflict for you.

I understand that having this evaluation does not guarantee that a diagnosis of a disability will be made by the RCLD.

I understand that admission to any college in the University System of Georgia is not guaranteed by a diagnosis of a learning disorder. Although some colleges may make special admissions considerations, I understand that admissions decisions are made based on high school GPA, SAT or ACT scores, fulfillment of RHSC requirements and other factors. Recommendations for specific accommodations are also not guaranteed and will be made based upon the determination of my individual pattern of processing deficits.

I understand that by signing this release of information and consent form that I agree to undergo evaluation and testing for learning disorders and related problems. I understand that this evaluation may be performed by doctoral psychology students under the supervision of licensed psychologists. I also understand that I will be given both verbal and written feedback regarding my evaluation results after they have been evaluated and reviewed by the RCLD's professional staff.

I understand that information collected in my evaluation may be included in group data for research purposes. This information can be used to increase understanding of the experience of students with learning disorders. If utilized for research purposes, this data will be coded in a manner that does not identify me personally, and will be analyzed at a group level. I am assured that identifying information will be removed, and my confidentiality will be protected.

**INITIAL**\_\_\_\_\_ I give permission for my assessment to be video recorded and viewed by the licensed psychologist who is responsible for my evaluation and for the purpose of supervision of the student clinicians involved in my evaluation. I understand that there may be occasions in which this tape may be viewed by other licensed psychologists and student clinicians in the RCLD during the course of the evaluation process for the purpose of supervising and training student clinicians. I understand that this video recording will be erased after my evaluation is complete.

**INITIAL**\_\_\_\_\_ I give permission for the RCLD to discuss scheduling and financial arrangements with my parents.

**INITIAL**\_\_\_\_\_ I give permission for the RCLD to gather information necessary for this evaluation from my parents.

**INITIAL**\_\_\_\_\_ I give permission for the RCLD to gather information necessary for this evaluation from the Disability Services provider at my college.

**INITIAL**\_\_\_\_\_ I give permission for the RCLD to contact my campus Disability Services Provider to provide them with information about the progress and status of my evaluation.

If you have any concerns about any of the procedures described herein, you may contact the Center Director, Regents Center for Learning Disorders, at (404) 413-6245.

_____ <b>Client Signature</b>	_____ <b>Date</b>	_____ <b>Age</b>
----------------------------------	----------------------	---------------------

_____ <b>Witness Signature</b>	_____ <b>Date</b>	_____ <b>Age</b>
-----------------------------------	----------------------	---------------------

\_\_\_\_\_  
**Parent Signature if Client is a minor (parents have access to evaluation results of minor children)**