Campbellsville UNIVERSITY
Phillips Education Center

DOCUMENTATION OF PERSONAL PSYCHOTHERAPY

I, _____ , give permission to _____
(PRINT STUDENT NAME) (PRINT THERAPIST NAME)

to disclose my participation in therapy as part of the graduation requirements in my Masters degree program at Phillips Education Center of Campbellsville University. This permission extends only to the fact of my participation and does not permit any disclosure of clinical material. Nor may this disclosure be made to any person or entity other than the Master of Marriage and Family Therapy Site Director, Co-Director(s) of Clinical Placement or Registrar's office at the Phillips Education Center of Campbellsville University. I understand that this document will be kept in my student education file and is protected by all the laws governing privacy of student records.

I, _____ _____
(NAME OF THERAPIST) (LICENSE OR ASSOCIATE #)

saw _____ as a psychotherapy client.
(NAME OF STUDENT)

Client attended _____ sessions beginning on ___/___/___ and ending on ___/___/___

_____
THERAPIST'S SIGNATURE DATE

_____
OFFICE ADDRESS

_____
OFFICE PHONE NUMBER

_____
STUDENT'S SIGNATURE DATE

Return completed form to the Clinical Training and Placement Co-Director(s)