



GRADUATE ART THERAPY PROGRAM  
EASTERN VIRGINIA MEDICAL SCHOOL  
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NORFOLK, VIRGINIA 23501-1980

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### CONSENT TO ASSESSMENT AND COUNSELING

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I consent to: \_\_\_\_\_ Assessment  
\_\_\_\_\_ Counseling

I understand that all services provided are supervised and information is disclosed in supervision to enhance planning.

I realize that information is confidential unless:

- a. I sign a form authorizing release of my records;
- b. I acknowledge intent to harm myself or others;
- c. I report abuse of a child or adult;
- d. my records are subpoenaed.

\_\_\_\_\_  
STUDENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PARENT/GUARDIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PARENT/GUARDIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
EVMS INTERN

\_\_\_\_\_  
DATE