University of Portland Health and Counseling Center
Informed Consent for GROUP Counseling Sessions

The signature below indicates my awareness and understanding of the following information pertaining to my participation in counseling groups offered through the University of Portland Health and Counseling Center.

I understand that:

1. The staff at UP Counseling Center adheres to professional, legal and ethical guidelines of confidentiality established by professional organizations and state laws. Exceptions to confidentiality are outlined in the Counseling Informed Consent and Confidentiality Statement which I have signed.

2. Confidentiality within the group setting is a shared responsibility of all members and leaders. While group leaders may not disclose any client communications or information except as provided by law, group members' communications are not protected. As such, confidentiality within the group setting is often based on mutual trust and respect.

3. As a member of this group, I agree to not disclose to anyone outside the group any information that may help to identify another group member. This includes, but is not limited to, names, physical descriptions, biological information, and specifics to the content of interactions with other group members.

4. The group will be led by a licensed mental health provider and may be co-facilitated by a predoctoral psychology practicum graduate student.

5. If I have any questions about the services I receive as a participant in the group, I can contact the group leader, the Associate Director for Counseling and Training, or the Health Center Director.

6. I acknowledge that group counseling is not intended to provide individual therapy services. If I feel that I require individual therapy sessions instead of, or in addition to, attending the group sessions, I will inform the group leader.

I am aware of, and fully understand, the above information.

Client Name: _____

Client Signature: _____

Date: _____