## GIL INSTITUTE FOR TRAUMA RECOVERY AND EDUCATION, LLC

### CLIENT CONSENT FORM FOR GROUP CONSULTATION

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Gil Institute for Trauma Recovery and Education, LLC is a group private practice in which therapists practice trauma-informed care utilizing current and integrated treatment approaches. Because all therapists are specialized in trauma and trauma-related fields, we have the opportunity to further our education and obtain qualified feedback during our clinical staff meetings. These clinical staff meetings are attended by psychotherapists who work full- or part-time at Gil Institute. In addition, we have monthly consultations with Dr. Eliana Gil, a Founding Partner of Gil Institute. Dr. Gil has over forty years of experience working in the field of childhood trauma, and is a recognized expert both nationally and internationally. Dr. Gil provides clinical leadership to Gil Institute therapists and clinical residents.

Informed consent by your signature below, grants your therapist the opportunity to obtain professional consultation and clinical direction. The primary purpose of these case consultations is to provide you access to clinical review and feedback from a group of well-trained professionals, in addition to Dr. Gil. Your therapist will present sufficient information to allow clinicians of Gil Institute to understand your circumstances and will then ask the group a specific consultation question. Those present during the consultation will provide your therapist feedback, which will then be passed along to you and your family for consideration. Dr. Gil and/or therapists working at Gil Institute, are bound to maintain you and your family's privacy and confidentiality. Additionally, identifying information about you or your family members will not be shared during the consultation session.

*I_____ give consent to _____ to discuss my family situation and to share video clips of our family sessions when appropriate. No taping will occur without your prior written consent and videotapes will be destroyed after the consultation. Confidentiality will be honored at all times by Dr. Gil and Gil Institute therapists, and information shared during consultation sessions will be treated with the utmost respect. I understand that I have the right to revoke this authorization at any time. I also understand that my provider will provide me with feedback regarding the group's discussion or specific recommendations when such are generated*.

Client or Parent Signature: _____ Date:_____

Printed Name: _____