



Alliance University Counseling Services

Students in Counseling Therapy Compliance Form

I, (Therapist's Name) Maggie Labocki confirm that
(Student's name) DWAYNE ROAN has participated in
5 session(s) with me
(number of sessions)

to fulfill the requirement of SF505, PPTFM.

Therapist Signature Maggie Labocki, LMHC
Date 4/6/2023

Student Consent Form

I, DWAYNE ROAN give Maggie Labocki, LMHC permission to
(Student Print Name & ID Number) (Therapist Print Name)

to release to Alliance Graduate School of Counseling (AGSC) and Alliance Theological Seminary the following information regarding my participation in the "Students in Counseling" requirements in compliance with HIPAA regulations.