Permission to Audio or Video Record Counseling Session
Clinical Mental Health Counseling

I hereby give permission to ________________________________,
(COUNSELOR IN TRAINING’S NAME)

a counselor-in-training at Medaille College who is completing clinical requirements at
________________________________________________,
(NAME OF SITE/AGENCY/SCHOOL)
counseling session/s. I understand that these recordings will be used only for the purpose of providing clinical supervision to the counselor-in-training, either at Medaille College or in the student’s clinical placement. Any person involved in providing or receiving clinical supervision is bound to the same ethical principal of confidentiality as professionals providing counseling. All tapes of counseling sessions will be erased no later than the end of the present academic semester. Any exception to this last statement would require an additional permission form to be signed by the client and counselor.

__________________________________________
(SIGNATURE OF CLIENT)  (SIGNATURE OF WITNESS)
__________________________________________
(DATE)  (DATE)

IF THE CLIENT IS A MINOR (UNDER 18 YEARS), HIS/HER PARENT OR LEGAL GUARDIAN MUST ALSO SIGN THIS AGREEMENT.

__________________________________________
(PARENT OR LEGAL GUARDIAN)  (DATE)

This form must be turned in to your Campus Supervisor. Keep a copy for yourself.