Appendix A: Northwest University Consent to Record Form

The Professional Practice student counselor named below is pursuing a graduate degree in Clinical Mental Health Counseling through Northwest University. The student counselor has a variety of training experiences and courses in pursuit of this degree. The student must pass rigorous evaluation and remain in good academic standing in order to work with clients. Clinical training requires demonstration of clinical counseling skill sets to program faculty, including audio or digital recordings or videotapes of sessions with clients. All recordings are handled within strict confidentiality guidelines according to HIPAA standards and are destroyed either immediately after being viewed or before the completion of the students' academic program. All Protected Health Information is maintained behind double locks to ensure only those allowed have access to the information _____ has requested.

Name of student counselor

_____

Name of person(s) seeking clinical mental health counseling

I, _____,

grant permission to have counseling sessions recorded (audio, video, digital, etc.). This permission allows the student counselor, clinical supervisors, and other students participating a supervision (no more than 12 counselors-in-training) follow strict ethical guidelines related to privacy and confidentiality of Protected Health Information. Exceptions to client confidentiality can only ethically and legally occur in cases in which the client is a harm to self or others; in cases of suspected abuse of minors or other at-risk populations; and, when a court subpoena requires verbal or written report of the content of client files. I/We understand giving Consent to Record is voluntary. I/We can request a recording be stopped at any time and can request no additional recordings take place.

If minors are participating in the clinical counseling session, please complete the following:
_____ I/We verify_____ has legal guardianship of the following

Minor(s): *Initials* *Printed name of guardian(s)*

Please choose one of the following and initial:

_____ I agree to allow my sessions to be recorded for the purpose of clinical supervision as described above.

_____ I do not agree to allow my sessions to be recorded for the purpose of clinical supervision.

_____ *Client or legal guardian signature*

Date _____ *Counseling student signature* _____