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. Additionally, students are asked to delete recordings prior to the completion of the program and/or in accordance with their site guidelines.

Student counselors store recordings for the purpose of supervision using the video assessment tool in the Experiential Learning Cloud (ELC), a cloud-based software platform for universities to manage student field placements and track hours. Northwest University has a Business Associate Agreement with the ELC ensuring that this platform is HIPAA compliant in storing Protected Health Information.

Name of student counselor

____

I/We, ____, (*name of person[s] seeking counseling*) grant permission to have sessions recorded (audio, video, digital, etc.). This permission allows the student counselor, clinical supervisors, faculty supervisors, and other students participating in 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 to take place.

If minors are participating in the clinical counseling session, please complete the following:

_____ I/We verify ____has legal
(Initials) Printed name of guardian(s)
guardianship of the following minor(s): ____

Please choose one of the following and initial:

_____ I agree to allow my sessions to be recorded for the purpose of clinical supervision

_____ 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 Date