

**Clinical Supervision Consent**

Clinical counseling supervision is a process; whereby, I engage another mental health professional for professional growth and development. Signing this consent allows me to discuss your treatment with another mental health professional for educational purposes.

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This consent may be revoked at any time except to the extent that the persons/agency, which is to make disclosure, has already taken action in reliance upon it. This authorization will expire one (1) year from the date signed. Also, I understand that a photocopy of this authorization is valid for release of the above information.

Signature of Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Signature of legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Signature of Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_