MERCER UNIVERSITY
COLLEGE OF PROFESSIONAL ADVANCEMENT

Department of Counseling
Clinical Mental Health Counseling Program

Client Permission to Record Counseling Sessions

I _____ agree to be counseled by or allow my child _____ _____ to be counseled by a Practicum or Internship student in the Master of Science in Clinical Mental Health Counseling Program at Mercer University. I understand that my identity will remain anonymous and all information will be kept in strictest confidence. I also understand the limitations of confidentiality.

I realize that the counselor is a graduate student being trained in counseling skills and that he/she is receiving supervision from a faculty member in the Clinical Mental Health Counseling Program at Mercer University. All recordings will be destroyed at the end of the student's clinical experience.

I understand that my counselor will be recording our sessions for his or her educational purposes only. I give permission for interviews to be recorded and for other counselors-in-training to listen to and/or watch those counseling sessions only when used as a part of their counselor training program. I understand I have a right to refuse to have any counseling sessions recorded in the future.

_____
Client's signature Date

_____
Parent or Guardian's signature Date
(if client is under 18 years of age)

_____
Counseling Student signature Date