Clinical Mental Health Counseling and School Counselor Education Program

PERMISSION TO RECORD/OBSERVE

I, _____, hereby give my permission
(Name of Client/Guardian – Please Print)
for the use of video-recording devices, as well as observation through a one-way mirror during my counseling session with

_____
(Name of Student Counselor)

at/from Eastern Kentucky University in conjunction with

_____

_____
(Site Name and Address)

I understand that any information obtained during counseling sessions through these means will be used solely for the purpose of supervision by my counselor's supervisor(s), and that otherwise this information will be kept strictly confidential.

This authorization will expire on _____ 20_____ or when I terminate my counseling with the above named counselor. I also understand that any taped material will be summarily erased after supervision has taken place.

Client Signature _____

Date _____ 20 _____