## INFORMED CONSENT FOR AUDIO/VIDEO RECORDING OF

## CLINICAL SUPERVISION

Clinical supervision is an essential component of my professional growth and development as a practicum/internship student as Waynesburg University. The recording of clinical supervision can serve as an educational tool. Recordings will protect client protected health information. As such, client PHI will not be shared and audio/video recordings of a student’s counseling session with client(s) will be excluded from recorded supervision sessions.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby give my consent for audio/video recording of my clinical supervision. I make all the necessary provisions to ensure confidentiality of the client(s) while supporting the educational needs of counselors and supervisors in training. I understand that I can revoke my consent at any time.

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Signature of Student Date

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Signature of Faculty Date