



## Master of Science in Counseling Program

CSG 891/892 Professional Internship

### Audio or Video Taping of Counseling Sessions Informed Consent

I, \_\_\_\_\_ understand that \_\_\_\_\_  
(Client Name) (Intern Name)

is a current student in the graduate program at Cairn University involved in internship training. I hereby authorize the above named intern to record our counseling sessions in the format indicated:

Audiotape:  Yes  No

Videotape:  Yes  No

I understand that the audiotapes or videotapes will be used by the intern only for training purposes and I give my consent for their review by the following individuals as indicated:

On-Site Supervisor:  Yes  No

CU Internship Course Professor  
and Class Members:  Yes  No

I understand that all information shared will be held in strict confidence and restricted to supervision and/or classroom usage only. I understand that all audiotapes or videotapes will be destroyed after they are used. I understand that I may withdraw my consent (except to the extent the tapes have already been reviewed) at any time by writing or, if I am physically unable to write, by orally advising the student intern or the On-Site Supervisor. I understand that my authorization covers only the format(s) and individual(s) indicated above. My signature below indicates my agreement to these terms.

\_\_\_\_\_  
Client Signature (or Parent/Guardian if under 18) Date \_\_\_\_\_