

**Department of Counselor Education & Family Therapy
Central Connecticut State University**

SAMPLE RELEASE FORM FOR RECORDING COUNSELING SESSION
(CNSL 503: PRACTICUM / CNSL 594: INTERNSHIP)

AGENCY/INSTITUTION LETTERHEAD

Name of Agency/Institution
Address
City, State, Zip

CONSENT TO RECORD FORM

CLIENT'S NAME: _____

COUNSELOR-IN-TRAINING'S NAME: _____

I, the client named above, give my consent to the counselor-in-training named above to audio/video/electronically record my counseling sessions. I understand that the above-named counselor-in-training is a graduate student in the Department of Counselor Education and Family Therapy at Central Connecticut State University (CCSU). I understand that my counselor is a student of professional counseling and is not yet licensed; however, I am aware that the student is under the supervision of qualified supervisors. The recorded counseling sessions, therefore, will be used solely by the student for the educational purposes of receiving specialized training, clinical consultation, and professional advice.

Furthermore, I understand that the counselor-in-training named above will share my recorded counseling sessions with the authorized parties identified below, who may listen to and/or watch the recordings for the purposes of direct clinical training. Any person (i.e., counselor-in-training / site supervisor / counselor education faculty member/ fellow counselors-in-training) listening to these recordings understands that the names and information contained within the tape will remain strictly confidential. I understand that the sharing of a recording of a portion of my session will be treated exactly like a counseling session and confidentiality will be maintained by all practitioners involved. By providing written consent to record my counseling sessions, I recognize that the above referenced student of professional counseling will be authorized to share the content, in individual and group supervision formats, with the following parties:

- On-site supervisor (an experienced counselor)
- Academic supervisor (a professor of Counselor Education at CCSU)
- Fellow student colleagues (other counselors-in-training who are enrolled in the practicum or internship course)

This authorization shall remain in effect until such time as I cancel the authorization in writing.

CLIENT'S SIGNATURE / DATE: _____

STUDENT'S SIGNATURE / DATE: _____

NOTE TO COUNSELING STUDENT: A signed/dated permission form **MUST** be obtained for each client prior to recording any part of a counseling session. These recordings may not be used for any other purpose without the client's explicit written permission. These recordings are to be erased or destroyed no later than the end of each academic year.