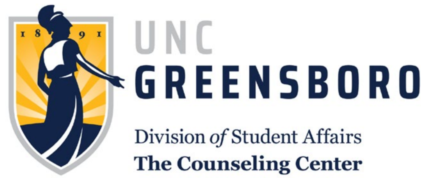

Counseling Center
Informed Consent for Treatment with an LCMHCA

Please read to the end and discuss with your mental health provider:

My therapist, Alishia McCullough, M.S., LCMHCA, is being supervised by Jennifer M. Whitney, Ph.D., LCMHCS. I understand that I am being asked to allow recording of my sessions via Telemental Health.

I understand that these Telemental Health recordings will be reviewed and discussed with my therapist's supervisor. Confidentiality is required of everyone with whom this information is shared. I understand that the material included on the recordings will be used only for the purpose of professional training and consultation. I further understand that the recordings will be erased after their use in supervision. I understand that these recordings may not be used for any other purpose without my explicit written consent.

My initials indicate that I give permission for my counseling sessions to be:

Recorded _______

My initials indicate that I give permission for recordings of my counseling sessions to be used in my therapist's individual supervision_________

I understand that I may rescind this permission at any time. Further, my consent or refusal of this agreement will in no way affect the services offered to me by The Counseling Center.

Client Name (print): ____

Client Signature: ____ Date: ______________