SYRACUSE UNIVERSITY
Department of Counseling and Human Services

PERMISSION TO AUDIO OR VIDEO RECORD
COUNSELING INTERVIEWS

I hereby give permission to _____,
(COUNSELOR'S NAME)

a counselor-in-training at Syracuse University who is completing clinical requirements at

_____, to make audio and/or video tape recordings of our
(NAME OF AGENCY/SCHOOL)

counseling interview. I understand that this recording will be used only for the purpose of providing clinical supervision to the counselor-in-training, either at Syracuse University or in the student's clinical placement. Any person involved in providing or receiving clinical supervision is bound to the same ethical principal of confidentiality as professionals providing counseling. All recordings of counseling sessions will be erased no later than the end of the present academic semester. Any exception to this last statement would require an additional permission form to be signed by the client and counselor.

_____ _____
(SIGNATURE OF CLIENT) **(SIGNATURE OF WITNESS)**

_____ _____
(DATE) **(DATE)**

IF THE CLIENT IS A MINOR (UNDER 18 YEARS), their PARENT OR LEGAL GUARDIAN MUST ALSO SIGN THIS AGREEMENT.

_____ _____
(PARENT OR LEGAL GUARDIAN) **(DATE)**