Eastern Mennonite University
SCHOOL OF GRADUATE & PROFESSIONAL STUDIES

Master of Arts in Counseling
1200 Park Road
Harrisonburg, VA 22802

Consent to be Recorded

I, _____, offer my consent to be recorded during counseling interviews. I understand that the recording will be listened to or viewed by counseling / faculty supervisors and a small group of graduate students for the purpose of counselor training. The intention of the recording is solely to address **counselor skills**, not client issues. I am aware that the recording will be erased after training exercise is complete and that confidentiality will be strictly enforced.

It is our policy to maintain the confidentiality of students and their records. According to the law and professional ethics, there are three exceptions to confidentiality:

1. State law requires that any counselor who suspects a child may be abused or neglected must report this to the Department of Social Services. This is also true when mentally or physically disabled adults are involved.
2. If a counselor believes you are in imminent danger of harming yourself or others, disclosure of information is required as necessary to ensure your safety and the safety of others.
3. If you are involved in a legal case in which your mental or emotional health is an issue, a judge may order the release of your medical record for the court to examine. We are required to comply with a court order.

If at any time for any reason you are dissatisfied with our sessions, please inform me or the Professional Practice Coordinator Dr. Jennifer Cline, who can be reached at 540.432.4213 or jennifer.cline@emu.edu. I assure you that my services will be professional and consistent with accepted ethical standards. Please note that counseling is in place for your personal growth and wholeness.

Additionally, should we find that you are in need of further support, we will explore referral possibilities to clinicians in the community.

Thank you for your willingness to participate in this learning experience.

Client Signature: _____Date:_____

Counselor Signature: _____ Date:_____