Release Form for Video/Audio-Recorded Interviews

Department of Counseling and Student Development
Eastern Illinois University

Practicum/Internship Instructor: _____

Site of Counseling Services: _____

Site Address: _____

Site Supervisor: _____ Semester/Year: _____

I _____ hereby give permission to _____ to

(Client's name) (Counselor's name)

video /audio record counseling sessions as desired throughout the current semester.

I understand that the video/audio recording will be used for training purposes and that viewing the recording will be restricted to the counselor's supervisor and the EIU instructor and counselors-in-training under the supervision of the instructor. I understand that any audio or video recordings will be kept in a secured location and will be erased at the conclusion of the internship/practicum unless further permission for its use is granted by me in writing.

The information shared in a counseling relationship is treated with the deepest respect. For the most part the information shared in a counseling session will not be repeated to anyone. We have an ethical responsibility to share some information. We are required by law to notify parents of any threats of suicide. We are also required to notify the proper authorities of child abuse, neglect and threats to harm others. We must also turn over records that are subpoenaed by a court of law. We hope that you understand our ethical and legal responsibility concerning these matters.

I understand that I may revoke this permission at any time.

Client's signature: _____ Date: _____

Client's name (Please print): _____

If the client/student is under the age of 18 years old, a parent or legal guardian must sign below.

I have read the above and I give my permission for _____

(Counselor's name)

to record counseling sessions with my child _____

(Child's name)

Signature of Parent/Guardian: _____ Date: _____

Parent/Guardian Name (Please print): _____

Address: _____

(Street) (City) (State) (ZIP)

Telephone: _____