

**LIU POST  
COLLEGE OF EDUCATION, INFORMATION & TECHNOLOGY  
DEPARTMENT OF COUNSELING AND DEVELOPMENT**

**EDC 668, Pre-Practicum and EDC 669, Counseling Practicum**

**INFORMED CONSENT FOR CLIENT TAPING**

I understand that my counselor-in-training is a graduate student-in-training.

I understand that my helping session(s) may be audio or videotaped for training and supervisory purposes; that only my counselor-in-training and those involved in the course will review any tapes; and that confidentiality will be strictly maintained in accordance with the law. Recordings will be destroyed in a timely manner.

I understand that all information shared in this session will be kept confidential, with a few key exceptions:

- (a) Professors and classmates may listen to the session or read transcripts of sessions (transcript will have no identifying information)
- (b) Intention to harm self or others, as required by law;
- (c) Reasonable suspicion of current or previous child abuse or neglect, as required by law;
- (d) Court orders

With the understanding that I may withdraw my consent to the above conditions at any time, I grant my permission to participate in the sessions(s) and to be audio/videotaped by the counselor-in-training whose signature appears below.

In case of emergency, please contact: Name \_\_\_\_\_  
Address \_\_\_\_\_  
Relationship to client \_\_\_\_\_  
Telephone number(s) \_\_\_\_\_

Print Client's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Print Client's Address: \_\_\_\_\_ Date: \_\_\_\_\_

Print Client's Telephone Number(s) \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Client: \_\_\_\_\_ Date: \_\_\_\_\_

Print Counselor-in-training Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Counselor-in-training: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian (if applicable) \_\_\_\_\_ Date: \_\_\_\_\_

University Instructor \_\_\_\_\_ Date \_\_\_\_\_