INFORMED CONSENT TO VIDEOTAPE

My signature below confirms that conditions of my consent to be videotaped have been explained to me, and I understand the following:

- I am not required to be videotaped and I am under no obligation to have this session recorded.
- I can withdraw my permission at any time during or after the session. **My access to counseling services will not be affected by my decision not to be videotaped.**
- I have the right to review this recording with my counselor during a counseling session.
- My counselor trainee receives supervision both at this location, NorthStar Regional, and by faculty at (ENTER SCHOOL NAME).
- This tape will be viewed during a supervisory group meeting at (ENTER SCHOOL NAME) by faculty and other counselor trainees as an educational opportunity to help train interns.
- Only my first name will be used or my name will not be mentioned; the contents of the tape will remain confidential within the supervision group of interns.
- The tape will be erased or destroyed upon completion of the supervisory and/or training review of this session.
- This consent expires 180 days from the date of my signature below. I may revoke this videotaping consent at any time prior to the expiration date by submitting to the counselor trainee a request to withdraw my permission.
- The original copy of this consent form will be kept in my records with this agency.
- I may contact the clinical supervisor through NorthStar Regional, (NAME AND #) or faculty at (School, name and #), if I have any questions.

_____ _____

(Signature of Client) (Date)

_____ _____

(Signature of Intern/Clinical Trainee) (Date)

_____ _____

(Signature of Site Supervisor) (Date)

NorthStar Regional
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