THE PENNSYLVANIA STATE UNIVERSITY
The Cedar Clinic
INFORMED CONSENT FORM

I understand that the Cedar Clinic is a training clinic, and that all services are provided by graduate students under faculty supervision. I understand that supervision may include one-to-one supervision between my counselor and his/her supervisor, group practicum supervision, live (behind a mirror) supervision by my counselor's supervisor or by a graduate-level trainee, and consultation with other professionals associated with the Cedar Clinic. To ensure quality student training and client service, there is a requirement that all counseling sessions be recorded on video (and possibly audiotape) for supervisory purposes only. The confidentiality of this material will be strictly safeguarded and all tapes will be erased subsequent to their use for supervisory purposes. These tapes may not be used for any other purpose without explicit written permission.

Please initial one of the boxes.

☐ Yes, you have my permission to audio/video tape my counseling session.

☐ No, you do not have my permission to audio/video tape my counseling sessions. I understand I will be referred to a counseling service where this is not a requirement.

If you checked Yes, please continue to read, if you checked No, please stop here.

I understand that all relationships with the counselors and clinic staff are considered confidential and personal records or information will not be released to any person or agency without my written consent. I understand that concerns about suicide, homicide, or child abuse may place limitations on confidentiality, in that the safety of individual lives is considered a priority to holding information confidential. Where lives are at risk, ethical and legal obligations of the profession dictate communication with official resources that may prevent loss of life or childhood injury.

In keeping with the University's support of research activities, I understand that the test data and counseling information may be used for research purposes but that no personal identifying information will be revealed without my written consent. I also understand that no research procedure will be performed that represents a risk to the client or adversely affects the services provided without advance written agreement to participate.

I have read the above statements, have had an opportunity to ask questions, and give my consent to receive services at the Cedar Clinic. I fully understand that counseling is voluntary and that I may terminate my involvement at any time by notifying my counselor, the Clinic Supervisor, or the Coordinator of the Clinic at 863-0048.

Client's Name	Witness' Name
Client's Signature	Witness' Signature
Date	Date