Wake Forest University
Department of Counseling

Phone Consent for Audio/Video Recording

(Parent/Guardian’s name printed)_________________________________________ was contacted on ____________ (date) by ____________________________________ (Counselor’s name) to be informed that his/her son or daughter has sought out counseling. The parent/guardian has given permission to see his/her son/daughter in counseling as well as to audio/video record these counseling sessions. The parent/guardian has been informed that these recordings are used for supervisory and educational purposes and may be reviewed in individual and/or small peer group supervision sessions. The policies of the audio/video recording procedure, supervision, and confidentiality have been explained and the parent/guardian has informed me that they understand. The audio/video recordings will be erased upon our completion of counseling.

______________________________
Counselor-in-Training Signature

Date

______________________________
Counselor-in-Training Name Printed

Date

______________________________
Witness to phone conversation

Date

______________________________
Student’s Name

Updated 10/10/13