



# Cleveland State University

College of Education and Human Services  
Counseling, Administration, Supervision and Adult Learning

## Clinical Mental Health Counseling Internship Consent Form

I am a graduate Student in the Clinical Mental Health Counseling program at Cleveland State University. The second field experience component of the Master's Program includes an internship experience. Internship is a term used to describe a learning experience under the supervision of a Professional Clinical Counselor with a Supervisor Endorsement (PCC-S). This Semester I am working under the supervision of

\_\_\_\_\_ (Supervisor's name) at \_\_\_\_\_ (agency). If the client is a minor, I need a parental/guardian consent to conduct counseling sessions with them.

As part of my training as a counselor, I am required to record some of my counseling sessions which are then reviewed by my university Internship Course Instructor. In order to conduct these recordings, I also need your consent. All tapes are kept in strict confidence and are used only for training purposes, and are therefore not a part of your client/patient record. Tapes are permanently deleted following completion of supervisory consultation. Should you have any questions or concerns at any time you can contact my university instructor, \_\_\_\_\_ (name) at (216) 687- 4613 and/or my site supervisor \_\_\_\_\_ (name) at \_\_\_\_\_ (number).

Please initial, after the activities you consent to, below. Please also sign and date the form at the very bottom.

Thank you for your consideration,  
Sincerely,

Professional Clinical Counselor Supervisor's Name: \_\_\_\_\_  
Client's Name: \_\_\_\_\_  
Parent/Guardian's Name: \_\_\_\_\_

I agree to allow \_\_\_\_\_ (CMHC CT) to conduct counseling sessions with \_\_\_\_\_ (Client's name). I understand that all information is confidential. \_\_\_\_\_ (initial here).

I also agree to allow counseling sessions with \_\_\_\_\_ (Client's name) to be recorded for educational growth purposes, which I understand will be destroyed once supervision is received. \_\_\_\_\_ (initial here).

Counselor Trainee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Client's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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