Mental Health Screening at Counseling, Health, & Wellness Services

What is screening at Counseling, Health, & Wellness Services (CHWS)? Screening hours provide an opportunity for brief consultation (around 20 minutes) to help determine appropriate services within CHWS, referral(s) to other supports, and/or next steps based upon current distress, presenting concerns, and availability of services.

In cases of emergency, students should contact Security Services at 253.879.3311 or ext. 3311 from a campus phone, or call 911 if off campus.

Please complete the following information to help us support you in getting the most out of this screening and to assist you with coordinating care:

CHWS generally is able to see students for individual counseling every 2-3 weeks. If you are seeking weekly therapy, you may be better served by seeing an off-campus mental health provider. Please speak to a CHWS counselor to help assess your needs for treatment.

Do you believe weekly therapy would best suit your needs? □ Yes □ No

Are you currently working with a therapist (either local or at home)? □ Yes □ No

If so, are you hoping to change therapists? □ Yes □ No

If so, please offer some additional context: __________________________________________________________

Which of our on-campus groups might address your concerns (see list on clipboard)? __________

___________________________________________________________

________________________________________

Are you covered by medical insurance? □ Yes □ No □ Not sure □

If so, is there any hesitation to using it? ___________________________________________________________

In your own words, briefly describe why you have come to CHWS today:

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

(Please Turn Over)
What this screening is not
- A thorough psychological assessment (i.e., “intake appointment”)
- Designed to provide quick answers for more complex questions or issues
- Sufficient to provide documentation for accommodations, study abroad, or medical withdrawal

Services outside our scope of practice
Counseling, Health, & Wellness Services provides outpatient treatment for a range of psychological conditions; however, we are not equipped to provide intensive or long-term care. If it is determined that we do not have the appropriate resources on our staff to meet your treatment needs, or if our treatment approaches are not proving effective, we may refer you to appropriate providers outside the college. Examples of issues where referral may be necessary include but are not limited to: history of multiple hospitalizations, chronic suicidality and/or self-harming behaviors, history of repeated suicide attempts, severity of alcohol or drug use that requires intensive outpatient or inpatient treatment, severity of an eating disorder that requires intensive outpatient or inpatient treatment, evidence of progressive deterioration in ability to function, need for formal psychological evaluation, and assessment of learning disability/ADHD or neuropsychological testing. Court-mandated assessments or treatment are not provided by CHWS.

By signing below you acknowledge having read and understood the above. If you have questions about this information, please ask your counselor before consenting.

Your name (print):___________________________________________________________________________________

Signature: __________________________________________________________________________________________ Date: ____________________
Welcome to Counseling, Health, & Wellness Services at the University of Puget Sound

If you are here for counseling, please complete both sides of this form. If you are here to discuss concerns about another person, only complete the front side.

Read and sign both copies of the Disclosure Statement. One copy is for you to keep. Read and sign the Notice of Privacy Practices. Read and sign the Request to Record Counseling Sessions.

If you have questions about any of these forms please discuss these with your counselor before signing them.

Today's Date ______________ Name ____________________________________________ Age________

Birth Date _______________ Gender ____________________ Pronouns ________________

Race / Ethnicity (ies) ___________________________ Country of Origin _________________

Sexual Orientation__________________________ Relationship Status____________________

Year: First ____ Second ____ Third ____ Fourth ____ Fifth+ ____ Grad student ___

Major ___________________________ Minor ___________________________

Campus Mailbox #: __________________________

Local address ________________________________________________________________

Street or Residence Hall Apartment or Room #

City Zip Code PREFERRED PHONE NUMBER

Hometown address ______________________________________________________________

Street Apartment #

City State Zip Code

Who, if anyone, referred you to CHWS? ____________________________. If this person inquires about your contact with CHWS, do we have your permission to acknowledge that you have been seen? (If you authorize this release of information, we would only confirm that you were seen in CHWS.)

YES ____ NO ____ _______________ ________________________________

Signature Date

Please continue on reverse side
COMPLETE THIS SIDE OF THE FORM IF YOU ARE SEEKING COUNSELING FOR YOURSELF.

Have you ever met with a psychologist, psychiatrist or counselor in the past? Yes ____  No ____

If yes, approximate date(s) ___________________________ Was it here at CHWS? Yes ____  No ____

Did you participate in ____ individual, ____ relationship, ____ family and/or ____ group therapy?

Are you currently taking any medications?  Have you taken psychiatric medications in the past?
______Yes   ______No  ______Yes   ______No

List current medications and supplements:
___________________________________________
___________________________________________
___________________________________________

List past medications and supplements:
___________________________________________
___________________________________________
___________________________________________

Have you ever been diagnosed with a mental health condition? Yes ____  No ____

If so, please list the condition(s):
__________________________________________________________________________
______________________________________________________________________________________________

Ever been hospitalized or received intensive treatment for mental health concerns?  YES ____  NO ____

If so, approximate date(s) ____________________________

Check the statement that best describes your current status:

______I am basically getting along OK, but feel I could use help sorting things out or doing things differently.
______I am experiencing serious emotional difficulty that is negatively affecting most or all parts of my life.
______I am feeling suicidal.

How is your general physical health?  ______ Excellent_____ Good_____ Fair_____ Poor

Medical Conditions: __________________________ Have you ever had a head injury? Yes ____  No ____

Please check ALL those items that help describe your concerns.

______Anxiety or nervousness in general
______Panic attacks or intense fears
______Avoiding leaving your room or social anxiety
______Personal growth issues
______Relationship issues
______Social skills or loneliness
______Family Issues
______Self-esteem
______Eating patterns
______Body image concerns
______Sexuality patterns, (in) experience or desire
______Sexual health concerns
______Alcohol or drug use
______Desire to change behavior
______Managing impulses/ Compulsive behavior
______Managing anger
______Mood swings
______Depression or feeling low
______Cutting, hitting or burning yourself
______Sleeping problems (too much or too little)
______Nightmares
______Suicidal thoughts or planning
______Homicidal Ideation/Thoughts of harming others
______Concentration difficulties
______Detached feeling from friends or the world
______Imagining things that are not real
______Conflict: __________
______Help adjusting to a change in my life
______Death or grief in response to a loss
______Physical abuse
______Emotional or verbal abuse
______Sexual assault or abuse
______Recovering from a trauma
______Harassment
______Academics
______Perfectionism or procrastination
______Career planning
______Headaches, stomach ache, muscle soreness
______AD/HD or a learning disability
______Physical disability
______Cultural identity
______Spiritual identity
______Gender identity
______Sexual orientation
______Social class/status identity
______Different identity issue: ________________
### GAD – 7

Over the last 2 weeks, how often have you been bothered by the following problems?  

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feeling nervous, anxious, or on edge.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Not being able to stop or control worrying.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Worrying too much about different things.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Trouble relaxing.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Being so restless that it’s hard to sit still.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Becoming easily annoyed or irritable.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Feeling afraid as if something awful might happen.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Add the score for each column: = = = =  

TOTAL score (add your column scores):  

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?  

- Not difficult at all: ____  
- Somewhat difficult: ____  
- Very difficult: ____  
- Extremely difficult: ____  

### Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?  
(Use a circle to indicate your answer.)  

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself; or that you are a failure; or have let yourself or your family down.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead, or of hurting yourself in some way.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Add columns + +  

TOTAL: ________  

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?  

- Not difficult at all: ____  
- Somewhat difficult: ____  
- Very difficult: ____  
- Extremely difficult: ____

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Audit-C Questionnaire

1. **How often do you have a drink containing alcohol?**
   a. Never
   b. Monthly or less
   c. 2-4 times a month
   d. 2-3 times a week
   e. 4 or more times a week

2. **How many standard drinks containing alcohol do you have on a typical day?**
   a. 1 or 2
   b. 3 or 4
   c. 5 or 6
   d. 7 to 9
   e. 10 or more

3. **How often do you have six or more drinks on one occasion?**
   a. Never
   b. Less than a month
   c. Monthly
   d. Weekly
   e. Daily or almost daily
Name:__________________ Date:__________

**The Cannabis Use Disorder Identification Test - Revised (CUDIT-R)**

**Have you used any cannabis over the past six months? YES / NO**

If YES, please answer the following questions about your cannabis use. Circle the response that is most correct for you in relation to your cannabis use *over the past six months*.

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Monthly or less</th>
<th>2-4 times a month</th>
<th>2-3 times a week</th>
<th>4 or more times a week</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How often do you use cannabis?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. How many hours were you “stoned” on a typical day when you had been using cannabis?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. How often during the past 6 months did you find that you were not able to stop using cannabis once you had started?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. How often during the past 6 months did you fail to do what was normally expected from you because of using cannabis?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. How often in the past 6 months have you devoted a great deal of your time to getting, using, or recovering from cannabis?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. How often in the past 6 months have you had a problem with your memory or concentration after using cannabis?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. How often do you use cannabis in situations that could be physically hazardous, such as driving, operating machinery, or caring for children:</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. Have you ever thought about cutting down, or stopping, your use of cannabis?</td>
<td>0</td>
<td>Yes, but not in the past 6 months</td>
<td>Yes, during the past 6 months</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*This scale is in the public domain and is free to use with appropriate citation:*

Please read the following information, ask any questions, and sign both copies of this document. Your signature acknowledges that you have read and understand the information below.

**Scope of Counseling Services** Based on the screening consultation students and providers collaborate to determine best treatment options. These might include short-term counseling in CHWS (group or individual treatments) or referral to off-campus providers for longer-term, specialized, or more intensive treatment needs.

During initial sessions, your provider will be working with you to determine the most appropriate, timely, and beneficial treatment options. If it is determined that we do not have the appropriate resources on our staff to meet your treatment needs, or if our treatment approaches are not proving effective, we will refer you to appropriate providers outside the college.

**Rights in the Counseling Process** Federal laws, the Washington Administrative Code, the Revised Code of Washington, and the Ethical Code of the American Psychological Association guarantee these rights to all people engaged in activities related to the practice of psychology:

- **Privacy (Confidentiality)** Information shared during counseling sessions is confidential. As allowed by law, your provider may consult with other health care professionals regarding your care. If you are being seen by a Psychology Intern or a Practicum Counselor, that counselor will be closely supervised by a Staff Psychologist who will be kept apprised of your progress, and will direct treatment planning.

  Information ordinarily will not be disclosed outside of CHWS without your written permission. However, there are exceptions to this rule by Washington State law. As may be needed to protect the safety of yourself and others, as allowed under Washington State Law, we are obligated by law to break confidentiality. If we suspect or learn of abuse or neglect of a child or vulnerable adult, we may be legally obligated to report that information. If your records are subpoenaed by a court, we may be required to comply with that order. We are required to report ourselves or another health care provider to the Department of Health in the event of a determination of unprofessional conduct, a determination of risk to patient safety due to a mental or physical condition, or if we have actual knowledge of unprofessional conduct.

- **Records** We maintain electronic records of services provided. This record of services is integrated with records of medical services provided in CHWS, thus, is accessible to all CHWS providers. We will not disclose your treatment record to others unless you direct us, or unless the law authorizes/compels us to do so, as described above. You may ask to see a copy of your health care record. In such cases, your provider will usually review the record with you. Please allow 15 days for any request for records.

- **Release of Information** Information about assessment and treatment can be released to third parties when you sign an authorization to release information. You may rescind an authorization to release information in writing at any time.

- **Appropriate Care** Your participation in mental health treatment at CHWS is voluntary and you have the right to these considerations: The right to be treated with dignity and respect, the right to receive care that is non-discriminatory, and the right to receive care from qualified staff.

- **Referral** Should you prefer to receive psychological services from someone other than the provider you have been assigned, you have the right to request a referral to another provider.

- **Risks of Treatment** When receiving mental health treatment there are potential risks given the nature of sharing very personal and private information with your provider. These risks may include general discomfort or experiencing strong emotions or feelings, which can be part of the therapeutic process. This is normal and can be discussed with your provider at any time.

- **The Right to Conclude Treatment** You have the right to conclude treatment at any time. If you have not had a session or made contact with your counselor within 45 days, your file may be closed. If you return to CHWS for
Appointments Mental health screenings and/or counseling is initiated in CHWS by meeting with a provider in a brief interview. These interviews are available on a first-come, first-served basis 1-4:00, M-F during the academic year. Any subsequent individual sessions are usually 50 minutes in length. Group sessions are 60 to 90 minutes in length. If an appointment time is reserved for you, please provide CHWS with 24 hours’ notice if you need to cancel/reschedule to allow the hour to be opened for another student. If you do miss an appointment but wish to continue, contact the CHWS receptionist or your provider to schedule or confirm your next session.

Charges There is no charge for regular counseling services provided by CHWS. Fees are assessed for missed appointments (described below). Fees are charged for some specialized assessments, including mandated substance abuse. These fees are specified in the paperwork you receive when referred for a specialized assessment. Fees for appointments with the CHWS psychiatrist are $35 for a 30 minute session and $65 for a 50 minute session.

No-Show Fees Failure to cancel an appointment within 24 hours’ notice will result in a $25 charge for counseling appointments, $65 for a 30 minute psychiatry appointment, and $125 for a 50 minute psychiatry appointment. If you received a charge in error, or there are extenuating circumstances to explain your missed appointment, you may appeal the charge by contacting the CHWS Director.

Ethical Conduct and Professional Standards If you have concerns about your treatment, you are encouraged to discuss them with your provider. Should you have reason to think your provider is practicing unethically, you may discuss the matter with the CHWS Director. You may also direct a letter of concern to the State of Washington Department of Health, Health Systems Quality Assurance, P.O. Box 47857, Olympia, WA 98504-7869, (360) 236-4700.

Summary of Staff Training Senior Psychology Staff are licensed psychologists. Our Doctoral Psychology Interns have completed their coursework and are in a final year of clinical training. Practicum Counselors are pursuing graduate degrees in counseling or psychology. Trainees provide treatment under the supervision of senior staff.

In Case of Emergency If you require emergency psychological care during our business hours (Monday-Friday, 8am-noon and 1-5pm) you can contact CHWS directly at (253) 879-1555. When CHWS is closed, you should contact Security Services at (253) 879-3311 if you are on campus or 911 if you are off campus. You may also contact the 24-hour Pierce County Crisis Line at 1-800-576-7764 or the National Suicide Prevention Lifeline at 1-800-273-8255.

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Social Media and Telecommunications Due to the importance of your confidentiality and maintaining appropriate boundaries of a therapeutic relationship, CHWS providers do not accept friend requests or contact requests from current or former clients on any social media platform (Facebook, Twitter, LinkedIn, etc). Similarly, CHWS providers do not conduct therapy over Skype or other like platforms.

I have read and understand the information provided in this document about my rights and responsibilities while working with Counseling, Health, & Wellness Services.

Client Name (print) __________________________ Signature __________________________ Date ________

Provider Name (print) __________________________ Signature __________________________ Date ________

Merlin/Forms/Counseling/Intake packet 2018-19/Informed Consent Final Draft 8/18 CE
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Client Name (print)  Signature  Date

Provider Name (print)  Signature  Date

Merlin/Forms/Counseling/Intake packet 2018-19/Informed Consent Final Draft 8/18 CE
Notice of Privacy Practices

To our patients and clients: As required by the Health Insurance Portability and Accountability Act of 1996, this notice describes how health information about you, as a patient or client of this practice, may be used and disclosed and how you can access your health information.

Our commitment to your privacy

Our practice is dedicated to maintaining your privacy. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated so we must provide you with the following important information:

Use and Disclosure of Your Health Information in Special Circumstances

The following circumstances may require us to use or disclose your “Protected Health Information” (PHI) without your authorization:

1. To public health authorities and health oversight agencies that are authorized by State and Federal law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official in order to comply with a court order or subpoena.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs if you file for these benefits.
Your Rights Regarding Your Protected Health Information:

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We attempt to accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including treatment and billing records. You must submit your request in writing to, Director of Counseling, Health, & Wellness Services (CHWS) at the University of Puget Sound (telephone 253.879.1555).

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To amend your record, your request must be made in writing and submitted to Director of CHWS at the University of Puget Sound (telephone 253.879.1555). You must provide a rationale supporting your request for amendment.

5. Right to a copy of this notice. You are entitled to a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy, contact CHWS at 253.879.1555 or write to chws@pugetsound.edu.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice. To do so, contact Director of CHWS, at 253.879.1555. Formal complaints must be submitted in writing. You will not be penalized for filing a complaint. Alternatively, you may file a complaint with the State of Washington Department of Health, Health Systems Quality Assurance, P.O. Box 47857, Olympia, WA 98504-7869, 360.236.4700.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this Notice, or about our health information privacy policies, please contact the Director of CHWS at the University of Puget Sound at 253.879.1555.

I hereby acknowledge that I have been presented with a copy of the University of Puget Sound’s Counseling, Health, & Wellness Services’ Notice of Privacy Practices.

__________________________________________________________________________
Signature

__________________________________________________________________________
Date Signed

__________________________________________________________________________
Printed Name

Rev 8.22 nm
Authorization to Record Counseling Sessions
Counseling, Health, & Wellness Service

Who might ask me to record my counseling sessions?
Any counselor may ask to record your sessions. We have counselors completing their final year of training in Clinical or Counseling Psychology before receiving their doctorates, called Psychology Interns. We also have students who are in training to become Counselors or Psychologists, called Practicum Counselors. Both Interns and Practicum Counselors have a supervisor who routinely reviews their work, thus they are most likely to ask to record sessions.

Why would my counselor ask my permission to record?
1) For quality assurance: To guarantee that Puget Sound students are getting the most skilled and ethical psychotherapy possible.
2) For treatment excellence: To add the perspective of another professional.
3) For training: We commit to providing trainees the highest quality supervision. Supervisors can give the most specific, meaningful feedback by observing recorded sessions.

Why me?
Reviewing recorded sessions is an expected part of the training to become a Psychologist and is common practice at most university counseling centers.

Who would review the recording?
Only members of the CHWS Psychology staff will review your recordings; all members of the Psychology staff hold recordings to the highest level of confidentiality. Typically only your provider and his/her/their supervisor will review your recordings.

How are the recordings protected?
Recordings are stored on a protected drive that can only be accessed by Psychology staff. We delete the recordings on a regular basis. Recordings are reviewed in CHWS.

It’s fine to say “No” to recording.
You are under no obligation to record any of your sessions at CHWS. If you believe that recording the session would interfere with your openness or trust, its fine for you to decline. Your therapy experience is the most important thing to us.

You can change your mind.
If you’ve granted your counselor permission to record, and later decide you’d rather not, you may rescind your consent. If you are working with a Psychologist or Intern, you will be able to continue with your counselor and simply not record sessions. If you are working with a Practicum Counselor, you will have to switch to another counselor if you rescind permission to record, as Practicum Counselors are required to record all sessions.

OVER >>>
Please sign the statement below that reflects your decision.

**Consent to Record Counseling**

I authorize recording of one or more sessions at CHWS. I understand recording is for the purposes of quality assurance, treatment excellence and training. I am aware that my permission will be re-confirmed at the beginning of any session to be recorded.

I give this authorization with the assurance that recording will be handled in a professional, confidential manner in accordance with the American Psychological Association’s ethical guidelines.

I realize that I have the right to withdraw my consent for recording at any time.

I consent to:  ____audio recordings  ____video recordings

Student name (print): ____________________________

Student signature: ____________________________

Date: __________________

**Decline Consent to Record Counseling**

_____ I have read the Authorization to Record Counseling Sessions form, and do not give permission to record sessions.

Student name (print): ____________________________

Student signature: ____________________________

Date: __________________