



**Form 9 - DISCLOSURE OF INFORMATION AND CONSENT TO
PARTICIPATE CLINICAL MENTAL HEALTH COUNSELING PRACTICUM
and INTERNSHIP**

COUN 5640, 5650, 5660, 5670

Introduction

The Counseling Program in Seattle University's College of Education is committed to excellence in preparing students for quality service in diverse communities. Counseling sessions provide an opportunity for graduate student counselor trainees to experience working with clients in an individual or group setting and to receive feedback and guidance from a Counseling Program faculty member and the trainee's peers in the Clinical Mental Health Counseling Program.

Clients have the right to choose counselors who best suit their needs and purposes. You are provided with the following information to assist you in making an informed decision to participate as a client with a graduate student counselor trainee.

Confidentiality

The content of all counseling sessions will be treated as confidential communications and will not be discussed outside of a clinical course or supervision session, except as described below. Consistent with professional ethics and legal requirements, there are special circumstances under which information about you and the services you receive as a client may be disclosed, including, but not limited to the following:

- a. A counselor trainee is required by state law to report knowledge of abuse, neglect and/or exploitation of children (under 18 years), developmentally disabled adults, or elders.
- b. If the counselor trainee believes that a client may be a danger to self or another person, the counselor trainee may be required to disclose health information to appropriate individuals or authorities.
- c. A counselor trainee may be subpoenaed or court-ordered to disclose information.
- d. If a client is gravely disabled due to mental illness/disability AND dangerous to self or others, information may be released to a county-designated Mental Health Professional if the client refuses to accept treatment voluntarily.
- e. Disclosure may be made to a person the counselor trainee reasonably believes is providing health care to a client including agency personnel.

Recording or Observation of Counseling Sessions

The counseling sessions serve an instructional, practice, and evaluation purpose for the student counselor-in-training. Therefore, the sessions may be recorded and/or may be observed by Counseling Program faculty, other graduate student counselor trainees, or on-site supervisors. Recordings are for educational purposes only and do not become a part of your health care records. Recordings are labeled "confidential" and do not

contain your name on the label. The recordings are not disclosed outside of the clinical course or the counseling site. All recordings are erased no later than three (3) months after the final counseling session.

Complaints or Concerns

If you have a complaint or concern regarding your counseling experience, we encourage you to discuss it with your counselor trainee; our experience suggests these experiences can be valuable. If this discussion is not to your satisfaction, please contact the supervising faculty member at 206-296-5750. Concerns regarding a licensed counselor in the Counseling Program may also be made to the Washington State Department of Health by writing to the Washington State Dept. of Health, Complaint Intake, P.O. Box 47857, Olympia, Washington 98504-7857, or by calling (360) 236-4700.

Consent and Acknowledgement

I certify that I have read and understand the information on this form. I understand that I may ask questions about the information on the form or the Counseling Program, services, or relationship. If I have asked questions about the counseling relationship, services or program, those questions have been answered for me. I understand that I am free to withdraw from the counseling relationship at any time.

I consent to participating as a client with a graduate student counselor trainee. I consent to observations, recording of counseling sessions for instructional purposes, including review and discussion of recordings or sessions by faculty, students, and on-site supervisors.

I am at least 13 years old and competent to give this consent.

Signatures:

Client Name: _____

Client Signature: _____

Date: _____

Name of Parent/Guardian: _____
(required if client is under 18 years of age):

Parent/Guardian Signature
(required if client is under 18 years of age):

Date

Counselor-In-Training Name: _____

Counselor-In-Training Signature

Date