

**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.

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Counselor-in-Training Signature

Date

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Counselor-in-Training Name Printed

Date

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Witness to phone conversation

Date

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Student's Name