

WESTERN WASHINGTON UNIVERSITY
Bellingham, WA 98225-9172

Department of Psychology **Counseling Training Clinic – Academic Instruction Center 453** Phone: 360-650-3184

CLIENT STATEMENT OF UNDERSTANDING

It is my understanding that I, or my dependent child (name of child: _____), will receive counseling and/or testing from a graduate counseling student who will be under the direct supervision of a psychologist or counselor educator in the Department of Psychology at Western Washington University.

I further understand that in order for the student to receive appropriate supervision, it will be necessary to have these sessions recorded. These recordings will be reviewed only by a qualified supervisor or by other counseling students under the direct supervision of the supervisor, and will be deleted when counseling is over. In addition, there will be times when other counseling students or supervisors observe sessions using the one-way mirrors. I agree to receive counseling under these conditions.

I further understand that any such record review or observation is for the primary purpose of aiding the counseling student to better help me or my child and other clients by improving the student's skills.

I understand that all information from the counseling interviews is to be kept confidential. However, I also understand that you (my counselor and his or her supervisor) are required by law to keep a record of the health care services provided to me. I understand that I may ask to see and copy that record (at the clinic office, Academic Instruction Center 453), and may also ask you to correct that record. My record will not be disclosed to others unless I direct you to do so or unless the law authorizes or compels you to do so. For example, a counselor and his or her supervisor are mandated by Washington State laws to make a report to appropriate agencies under the following circumstances: when made aware of any client's intent to harm self or others, or when informed of abuse of a child, an elderly or developmentally disabled person.

In addition, due to the training nature of this clinic, there may be instances in which the student's supervisor determines that the clinic is not appropriate for a client. The following are a few specific examples in which such a determination might be made: disorders requiring long-term therapy, regular client safety monitoring, extensive medication supervision, or intervention strategies beyond the scope of counseling graduate students, such as hypnosis or biofeedback.

In keeping with the University's support of research activities, I understand that the test data and counseling information may be used for research purposes but that no personal identifying information will be revealed without my written consent. I also understand that no research procedure will be performed that represents a risk to the client or adversely affects the services provided without advance written agreement to participate.

I understand that my health care records are protected by the Health Insurance Portability and Accountability Act (HIPAA). I understand that in the unlikely event that the security of my healthcare information is compromised, the Clinic Director will inform the WWU HIPAA officer and that I will be informed of any serious breaches in security.

Considering all of the above, I hereby grant my permission to be recorded and observed during these counseling and/or testing sessions.

Signature (all clients)

Date

Signature (Parent/Legal Guardian if client is under 13 years of age)

Date

12-12-13