ALL ADULT CLIENTS

CLIENT RELEASE AND INFORMED CONSENT

The rights for clients receiving counseling by a graduate counseling student from the Department of Counselor Education at Western Illinois University are as follows:

1. To be treated with respect, consideration, and dignity.

2. To be assured confidential treatment of their disclosures except

- when mandated by law, such as in cases of physical or psychological child abuse, incest, child neglect, and abuse of the elderly;
- when it is necessary to protect clients from harming themselves or to prevent a clear and immediate danger to others;
- when subpoenaed or court ordered by a court of law [‘privileged communication’ does not exist between a counselor and client (s)]

3. To be afforded the opportunity and responsibility to approve or refuse release of records.

You are encouraged to talk openly and without reservation about your thoughts, reactions, perceptions, and feelings.

I verify that I have been informed of my rights and privileges as outlined above. I understand that all information revealed in these sessions will be held in strictest confidence, except for the reasons outlined above or when authorized by me, in writing, to release it.

I also authorize the digital recording of all sessions that I attend. I also understand that these recordings are used for supervision, with full recognition given to the rights of the individuals involved.

I further consent to allowing graduate counseling students, and instructors to view these recordings or observe sessions in progress.

Client Signature: ____

Date: ____

Counselor Trainee’s Signature: ____

PARENTAL CONSENT AND CHILD ASSENT FORM

Client's Name:____

Address:____

____

Phone (home/office): ____

The Department of Counselor Education at Western Illinois University prepares its students for Internship, which emphasizes the development of clinical skills for students. Students are required to record counseling sessions as part of their course degree requirements.

Counselor trainee, ____, is available to work with your son/daughter, a student at__________________________ (community agency/school). The counseling sessions conducted with your child will be recorded and will be reviewed by the student's supervisor *(name)*:____________________________. All digital recordings made will be erased permanantly from any devices used to make the recordings at the completion of the semester. All data will be encrypted using at least 128 bit encryption standards for the client's protection.
Thank you for your cooperation.

Parent's Signature : ____

Student/Client Signature: ___________________________________

Date: _________________

Counselor Trainee's Signature: ________________________________

HIPAA AUTHORIZATION FORM

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I authorize my counselor ___________________________________ and/or his or her
(counselor's name)
administrative and clinical staff (cross out if not applicable) _________________________________
to release (provide description of the information that you want disclosed. Your description should be as specific and detailed as possible.)

____

____

This information should only be released to (name and address of person to whom the information is to be released)

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____

I am requesting my counselor to release this information for the following reasons: ("at the request of the individual" is all that is required if you are my client and you do not desire to state a specific purpose.)

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This authorization shall remain in effect until (fill in expiration date) (if no calendar date is stated, information may be released only on the day the authorization form is received from the counselor).

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You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my counselor generally may not condition counseling services upon my signing an authorization unless the counseling services are provided to me for the purpose of creating health information for a third party.

I understand that I have the right to inspect the disclosed mental health information at any time.

I understand that Illinois law prohibits re-disclosure of any information disclosed to the recipient pursuant to this authorization unless this authorization specifically authorizes such re-disclosure.

_________________________________ _______________________
(signature of client) (date)

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If the authorization is signed by a personal representative of the client, a description of such representative's authority to act for the client must be provided.