



Consent to Record

Name of Therapist or Intern: _____

Name of Client: _____

Print Name of Person Signing Form: _____

I hereby give permission for the therapist or intern named above to record audio or video sessions for the purpose of assessing the counseling skills of the therapist/intern in supervision.

Client (or Guardian) signature

Date

Our mission is to provide professional counseling from a Christian perspective to bring about healing to individuals, couples, and families in the greater Charlotte area