U.S. NAVAL ACADEMY MIDSHIPMEN DEVELOPMENT CENTER AUTHORIZATION FOR TREATMENT AND AUDIO-VIDEO RECORDING WITH A PSYCHOLOGY EXTERN AND A CLINICAL SOCIAL WORKER INTERN

PRIVACY ACT STATEMENT:
AUTHORITY: U.S.C 301, Departmental Regulations, 10 U.S.C. 5013, Secretary of the Navy; 10 U.S.C. § 6951a - U.S. Code - Unannotated Title 10. Armed Forces § 6951a-Superintendent; DoDI 1322.22, Service Academies; 10 USC 136, Secretary of Defense For Personnel and Readiness; DoDD 1145.2, United States Military Entrance Processing Command; DoDI 6130.03, Medical Standards for Appointment, Enlistment, or Induction in the Military Services.
PURPOSE: Provide a record of Midshipmen Development Center client consent for treatment and audio-video recording with a psychology extern and a clinical social work intern.
ROUTINE USES: Used by the staff of the MDC to maintain a record of authorization of clients for treatment and audio-video recording with a psychology extern and clinical social worker.
DISCLOSURE: Voluntary.

I hereby agree to participate in counseling with a Psychology Extern, who is a graduate student seeking a doctoral degree in clinical or counseling psychology, and/or a Clinical Social Worker Intern, who is a graduate student seeking a Master degree in clinical social work, who are under the supervision of a licensed clinical social worker and/or licenced psychologist on staff at the MDC.

I am aware that my counseling may involve discussions of my case with other mental health professionals and doctoral students in psychology. Any information that would identify me with anyone other than my counselor's direct MDC supervisors will be excluded from such discussions.

My counseling may also include RECORDING of an assessment, intervention, consultation, or supervision/teaching/management activity. The activity will be recorded for review by the clinical supervisor overseeing the care provided by my counselor, with the purpose of ensuring that I am receiving quality care and services. No one other than those involved in my counselor's supervision will be allowed access to the recording. The recording will be deleted/destroyed after it has been reviewed.

- I have received the name and contact information of the primary clinical supervisor overseeing my care.
- I understand that if I have any concerns regarding my treatment, I will discuss this with my assigned counselor; however, I am aware that I may address any concerns with my counselor's supervisor.
- I recognize that my participation in the recording process is entirely voluntary and not a requirement to receive psychological services at the MDC.
- I understand that I may revoke this authorization for recording at any time without adverse consequences and that I have had any and all questions answered prior to signing.
- I have been asked if I would like to receive a copy of this consent form.

1. CLIENT ALPHA NUMBER:	2. CLIENT BATTALION:	3. CLIENT COMPANY:
4. CLIENT NAME *(Last, First, Middle Initial)*:	5. CLIENT SIGNATURE:	6. DATE:
7. MDC EXTERN *(Last, First, Middle Initial)*:	8. MDC EXTERN SIGNATURE:	9. DATE:
10. MDC SUPERVISOR *(Last, First, Middle Initial)*:	11. MDC SUPERVISOR SIGNATURE:	12. DATE: