INFORMED CONSENT FOR CLINICAL TRAINEE/CLINICAL INTERN TO PROVIDE MENTAL HEALTH SERVICES TO CLIENTS

Client's Name: ___________________________ Client's Number: ______________

By signing this consent, I permit the below-named Clinical Trainee/Clinical Intern to provide mental health services to either myself or to an individual for whom I have legal guardianship. I understand the Clinical Trainee/Clinical Intern:

- Will Not have their supervisor present during therapy sessions;
- Receives supervision by a licensed mental health professional employed by Southern Minnesota Behavioral Health and, if a Clinical Intern, academic internship supervisor from their college or university;
- Will be reviewing my case with their Southern Minnesota Behavioral Health supervisor for purposes of evaluating the Clinical Trainee's/Clinical Intern's clinical skills;
- Will be held to the same professional and legal standards, which includes protecting my confidential information as Licensed Mental Health Professionals.

____ ___________________
Signature of Client/Parent/Legal Guardian Date

____ ___________________
Signature of Clinical Trainee/Clinical Intern Date

____ ___________________
Signature of Southern Minnesota Behavioral Health Supervisor Date

A copy of this document will remain a part of your records consistent with the Minnesota Data Privacy Act and HIPAA. This authorization expires one year from the client signature date.