CONSENT FOR STAFF/VOLUNTEER/INTERN OBSERVATION

The undersigned client* or responsible party** consents to and authorizes staff and/or interns of:

_____
Name of Facility and/or Program or Unit and Employee Name

to observe mental health sessions for purposes of education, training and/or quality of service.

The undersigned understands:

1. He/she has a right to refuse to allow other staff to observe sessions at any time.
2. The signing of this form has no impact on the provision of services.
3. The observation will only be by staff, volunteers and/or interns for purposes of education, training and/or quality of service.
4. This consent is voluntary.
5. This consent remains valid unless the client* or legal representative** withdraws his/her consent or the client is discharged from services.
6. The observation may be done from behind a one-way mirror/window or within the room with him/her and his/her mental health provider.

_____ _____
Signature of Client* Date

_____ _____
Signature of Responsible Party/Relationship to Client** Date

_____ _____
Clinical Staff Signature & Print Date

_____ _____
Supervisor Signature & Print Date

This consent was interpreted in _____ for the client and/or responsible adult. If a translated version of this Consent was signed by the client and/or responsible adult, the translated version must be attached to the English version.

* A minor client receiving services under his/her own signature must have the signed Consent of Minor form on the file in the clinical record.
** Responsible Adult = Guardian, Conservator, or Parent of minor when required.

Signator ( )was given or ( )declined a copy of this Consent on _____ by _____
Date Signature

This section must be completed by Staff when there is no signature by the client and/or responsible adult or if consent is withdrawn.

☐ Client is willing to accept services, but unwilling to sign this consent.
☐ Client does not wish to be observed.
☐ Client had previously provided Consent but now wishes to withdraw Consent as of _____ (date)

_____ _____
Signature of Staff Date

This confidential information is provided to you in accordance with applicable Welfare and Institutions Code Section 5328. Duplication of this information for further disclosure is prohibited without the prior written consent of the patient/ authorized representative to who it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.	Name: IS #: Agency: **Enki Health & Research Systems, Inc.** Location: