Clinical Supervision Consent Form

I _____ understand that my therapist,Doug Borrmann,M.S LAC is working under the clinical supervision of **Jennifer Cecil, M. Ed LPC. He/She** may at times be sharing the content of our sessions with his/her clinical supervisor. All attempts to guard my confidentiality will me made. I may contact Jennifer Cecil at **602 694 5403** or at counselorjen@aol.com at any time.

_____

Client Signature Date

_____

Therapist signature Date

_____

Clinical Supervisor signature Date