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PERMISSION TO DIGITALLY RECORD THERAPY SESSIONS

Therapist Explanation:

For the purpose of enhancing our work together I may ask to video record you during specific dialogues or exercises, or during entire session. I may wish to use the video recorded material to receive peer consultation. This may occur during the time of treatment or thereafter for purposes of peer review, education and quality assurance. During this process, your name will be kept confidential. In addition, all matters discussed in consultations will remain completely confidential within the consultation setting. The video recorded material will used for no other purpose without your express written permission and it will be erased when they are no longer needed for these purposes.

The video recorded material is my property and will remain solely in my possession during the course of your therapy. Should you wish to review this material for any reason, we will arrange time to do so. This material will remain in locked facilities at all times.

I understand and accept the conditions of this statement and give my permission to have my therapy sessions video recorded.

Client(s) Agreement:

I understand and accept the conditions of this statement and give my permission to have my therapy sessions video recorded. I understand I may revoke this permission in writing at any time, but until I do so, it shall remain in full force and effect.

Client / Parent/ Legal Guardian (PRINT)	Signature	Date
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Client / Parent/ Legal Guardian (PRINT)	Signature	Date
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Therapist (PRINT)	Signature	Date
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