CONFIDENTIAL PATIENT INFORMATION: See California Welfare and Institutions Code Section 5328

San Mateo County Health System
Behavioral Health & Recovery Services

AUTHORIZATION for SESSION RECORDING and/or 1-WAY MIRROR OBSERVATION

Client Name _____ **MH Number** _____

I do hereby give my consent to have counseling sessions observed and/or recorded.

I understand that this taping will be treated with complete confidentiality and will be discussed only with the clinical staff within this agency and, in the case of clinical trainees, with the immediate clinical supervisor of the trainee. If the taping is discussed in an educational setting no clients or families will ever be identified by name.

This authorization shall be valid until _____. In all circumstances, the consent must be renewed annually.

I consent to the following conditions:

1. Audio Recording
2. Audio/Video Recording
3. One-Way Mirror Observation
4. Other (specify) _____

I understand that my consent is voluntary and may be withdrawn at any time.

Signature _____ **Date** _____
Client/Legal Representative

If signed by someone other than the client, state legal relationship to the client:

_____

Original to Client Chart

cc: Client
Authorized Clinician