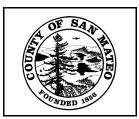
CONFIDENTIAL
PATIENT
INFORMATION:
See California
Welfare and
Institutions Code
Section 5328

## San Mateo County Health System Behavioral Health & Recovery Services

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



Clien	ent NameMH	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.		
	s authorization shall be valid until cumstances, the consent must be renewed annually.	In all
I cons	onsent to the following conditions:	
1.	1. Audio Recording	
2.	2. Audio/Video Recording	
3.	3. One-Way Mirror Observation	
4.	4. Other (specify)	
I understand that my consent is voluntary and may be withdrawn at any time.		
Signa	nature	Date_
	Client/Legal Representative	
If signed by someone other than the client, state legal relationship to the client:		
Origin	ginal to Client Chart	
cc:	Client	
	Authorized Clinician	