Authorization for Session Recording and/or One-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I understand that my consent is voluntary and may be withdrawn at any time.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