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I understand that my consent is voluntary and may be withdrawn at any time.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

http://www.smchealth.org/BHRS-Documents
QI-Intranet\Consents\Auth Record Session rev4-09.doc
QI-Clinical Forms\Consents