



PERMISSION TO RECORD & OBSERVE THERAPY SESSIONS

In this practice, we utilize several research-based models (Play therapy [PT], Parent Child Interaction Therapy [PCIT], Eye Movement Desensitization & Reprocessing [EMDR], Cognitive Behavioral Therapy for Insomnia [CBT-I] and Emotionally Focused Couples [EFT] and Family Therapies [EFFT]), Maternal Mental Health Treatment [MMH] and Group Therapy, and many other modalities, all of which subscribe to a process of consultation/supervision where sessions are recorded and observed by consultants/supervisors, then used for learning purposes by the therapist, the consultant and the couples/clients. In order for sessions to be recorded or observed, you must give your written consent.

In signing this form, I understand that:

1. Any consultants who observe or hear these recorded sessions are held to the same confidentiality standards as my therapist.
2. If by chance any consultant or supervisor knows me socially, he/she will immediately stop the recording, will not observe or be given any information about my therapy.
3. One of the purposes of allowing observation and recording of my therapy sessions is to promote the effectiveness of the therapy (EFT, EFFT, PCIT, or PT) that I am receiving from my therapist.
4. My therapist owns the video/audiotapes, which are not a part of my medical record.
5. Tapes are secured and password protected, then destroyed at regular intervals.
6. I may withdraw this consent at any time for any reason without any questions asked.
7. If tapes are sent to supervisors in any form, I consent for tapes to be sent via FedEx (since the package is tracked constantly while en route) without any identifying information on the DVD. Recordings may also be shared through our HIPAA compliant platform, (Zoom). I understand that the supervisor/consultant destroys the tapes after providing the consultation/supervision.

Consent:

By signing below, I give my consent to allow therapy sessions with

_____ (therapist) to be observed via video or heard via

audiotape _____ (supervisor).

This consent is valid for one year from the date below.

Client Name: _____

Client or Guardian Signature

Date

Client or Guardian Signature

Date

Therapist Signature

Date