everbreeze

Consent to Audiotape/Videotape Sessions

I, _____, consent to have my/ my child's psychotherapy session recorded via audio/videotape in order to further my/my child's treatment. I further understand that confidentiality of all recorded sessions will be maintained. Only Corinne J. Lewkowicz, Ph.D., will have access to the recorded sessions, and no session will be recorded in whole or in part without my and/or my child's express consent. The purpose for recording the session(s) will be clearly explained, and all questions will be answered fully.

I acknowledge that I have had all my questions about the purpose of any recordings answered fully and to my satisfaction.

My signature below indicates my understanding and agreement with the above statements.

_____ _____

Signature of Client/Parent/Guardian Date

_____ _____

Printed name of Client/Parent/Guardian Relationship to client

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist Date

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.