Authorization for session(s) to be videotaped

1. Client's Name: ____

First Name Middle Initial Last Name

2. Date of Birth: ______ / _____ / __________

3. Date authorization initiated: ______ / _____ / __________

4. Authorization and Signature:

I hereby give permission for therapy sessions to be videotaped for the sole purpose of receiving clinical feedback from my clinical supervisor and/or consultant. This authorization is completely voluntary and may be revoked at any time.

After the session is reviewed by my clinical supervisor and/or consultant and feedback is given to therapist, the video file will be deleted.

____ ________________

Signature of Client * Date

____ ________________

Signature of Parent/Guardian * Date

* If client is between the ages of 12-17, the signature of both minor and parent/legal guardian is necessary

____ ________________

Signature of Witness Date