211 S. Primrose Ave.
Monrovia CA 91016
(626) 359-4330

Consent for Audio/Video Recording

I consent to allowing _____(insert practitioner name) of The Place Within to record sessions via audio or video means. My therapist has explained to me the potential benefits and drawbacks related to this and how it may impact my treatment.

I understand that my therapist will be recording sessions for the purpose of supervision/consultation related to obtaining certification in the mental health field. I understand this will allow other professionals to access my Personal Health Information such as my name, purpose for seeking treatment, treatment goals, and all recorded material from sessions.

However, this information will only be shared for the purpose of supervision/consultation and only with those persons related to certifying my therapist will have access to recordings. These recordings will NOT be used for research or any other purpose without my further written consent.

I understand the laws that protect the confidentiality of my Personal Health Information apply to recordings, as do the limitations to that confidentiality discussed in the Consent for Services.

I understand that my therapist will destroy all recordings 1) in accordance with the record keeping guidelines of the State of California and the ethics of the profession or 2) once they have served their purpose, whichever is sooner. All recordings will be destroyed in a manner which protects my confidentiality.

I have the right to withhold or withdraw this consent at any time and this will not impact my treatment in any way.

I also have the right to request we discontinue recording during any session and to request any recorded portion be destroyed or erased immediately.

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I have read and understand the information provided above. I have discussed it with my therapist, and all of my questions have been answered to my satisfaction.

Client Signature	**Date**
Parent/Guardian Signature (if applicable)	**Date**