

Release and Permission to Record Sessions and to Use Case Materials

I would also be grateful for your consent to use your case material in my other professional activities. Your material may help in the development of the mental health field or in the training of future mental health workers. It is possible that I could use your material in teaching, supervision, consultation with other therapists, publishing, or scientific research. For these purposes, I might use any of the following:

- Audio or video recordings of our sessions

When I use materials from my testing or therapy work, I do not want anyone who hears, reads, or sees it to be able to identify the clients involved. Therefore, I would conceal your identity by one or both of these two methods:

1. Report the results as grouped data (that is, publish only numbers like averages, and not publish anyone's names).
2. Remove (or, if this is not possible, greatly change) all names, dates, places, descriptions, or any other information by which you or anyone else involved could be identified. In particular, I will not use, or allow anyone else to use, your real name in any presentation of any of these materials.

These materials will be shown only to other mental health professionals and to their students. All of these persons are bound by state laws and professional rules about clients' privacy. I will keep all these materials in a safe location, and destroy them as soon as they are no longer needed.

Therefore, I am asking you to read and sign the following:

I, the client (or his or her parent or guardian), consent to the recording of my therapy sessions for the purposes described above. This recording may be done by video and/or audio taping, by video cassette, by video disc, or by any other means. The purpose and value of recording have been fully explained to me, and I freely and willingly consent to this recording.

This consent is being given in regard to the professional services being provided by the therapist named below. I agree that there is to be no financial reward for the use of the recordings. I understand that I will not be punished in any way if I do not wish a particular session to be recorded. I understand that I may ask for the recording to be turned off or erased at any time during my sessions. I also understand that within 5 days following a session, if the video taped session has not been already destroyed, I may choose to request a viewing of the recording with the therapist. I further understand that I may then ask for the recording to be destroyed.

I understand that I am fully responsible for my own participation in any and all exercises and activities suggested by the therapist. I agree not to hold the therapist legally responsible for the effect of these exercises on me, either during the therapy session or later.

I give the therapist named below my permission to use the recordings of me for research, teaching, and other professional purposes. I understand that they will be used as an aid in the process of improving mental health work or training mental health workers. I understand that the therapist will contact me directly each instance he/she wishes to use one of my tapes for training purposes. I am under no obligation to consent to my/my child's tape being viewed for training purposes.

I hereby give up my rights to any and all interests that I may have in the recordings. I agree to let the therapist be the sole owner of all the rights in these recordings for all purposes described above.

Signature of client (or parent/guardian)

Date

Printed name

I, the therapist, have discussed the issues above with the client (and/or his or her parent or guardian). 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

✓ Copy accepted by client ✓ Copy kept by therapist

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