

## PERMISSION TO VIDEO TAPE THERAPY SESSIONS

I/We \_\_\_\_\_  
consent to the video taping of therapy sessions with \_\_\_\_\_.  
I/We are aware of the presence of the video equipment and permit the use of all or part of the  
video tapes for the purpose of: (please initial below the type of use you are permitting)

\_\_\_\_\_ (initial) Our therapist to assist in our therapy for educational review.

\_\_\_\_\_ (initial) Our therapist's consultation with a clinical supervisor(s) and/or training group.

In no way will the refusal to grant consent for this video taping effect my/our getting assistance  
for myself/ourselves. If at any time during the treatment process, we wish to stop the taping we  
may do so and still continue treatment.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

Therapist's Signature: \_\_\_\_\_

Therapist's Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_