CONSENT FOR RECORDING (AUDIO/VIDEO)

I/We give permission for audio/video recording (circle one) of therapy/assessment (circle one or both) sessions with _____ (name of student). I/We understand that this permission may be withdrawn at any time. I/We understand that recordings will be reviewed exclusively for the purpose of supervision and training by graduate students and their supervisor or Practicum and Internship Seminar Instructors at Columbus State University, where the strictest standards regarding confidentiality are maintained. Any and all recordings will be erased or deleted immediately after supervision, and no identifying information [e.g., my/our name(s)] will be on or accompany the recording(s). I/We understand that although this agreement reflects the recording of multiple sessions, no session will be recorded without my/our knowledge.

_____ _____
Signature of Client Date

_____ _____
Signature of Client 2 (If couples or family) Date

_____ _____
Signature of Parent (If applicable) Date

_____ _____
Signature of Student Intern Date

_____ _____
Signature of Witness Date