Written Release and Permission to Record Sessions

for Clinical, Supervision, Training, and Professional Presentation Purposes

Video and audio recordings are sometimes used as aids in the therapy process, for the therapist's own personal review of a particular therapy, interview, or testing session, or for trainings and professional presentations with other clinicians. Any such recordings will be kept confidential, viewed with discretion, and will only be viewed by the program therapist, clinical supervisors, clinical trainees, and training and presentation participants and will not be released to another party without your additional written consent. These recordings/materials will be encrypted and kept in a secure, safe location in accordance with HIPAA regulations. I understand that when I, the client, am in possession of the recordings off BCSC grounds (e.g., at home or in another location while reviewing a recording using a personal computer) it is my responsibility to ensure they are stored safety and securely. Therefore, you are being asked to read and sign the following:

I, _____, 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 my consent is completely voluntary and refusal to provide consent will not limit the care I receive at BCSC (unless the treatment recommended requires the use of audio/video recording for clinical purposes). 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 at any point following a session, 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 at any point during or after the treatment process. 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.

BCSC

Boston Child Study Center

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Expert Mental Health Treatment, Training & Research

I give the therapist and their supervisors at BCSC my permission to use the recordings of me as aids in the therapy process, for the therapist's own personal review of a particular therapy, interview, or testing session, or for training and professional presentation purposes. I understand that my therapist is bound by state laws and by professional rules about clients' privacy. I hereby give up my rights to any and all interests that I may have in the recordings. I agree to let the therapist and his or her supervisors be the sole owners of all the rights in these recordings for all purposes described above.

_____

Signature of client Date

_____

Printed name

_____

Signature of parent/guardian (if client is < 18 y/o) 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