



3145 E. Chandler Blvd 110-117, Phoenix, Arizona 85048 | Phone 602.828.2619 |

Release and Permission to Record Sessions

Video and audio recordings are sometimes used as aids in the therapy process, or for the therapist's own personal review of a particular therapy, interview, or testing session. Any such recordings will be viewed with discretion and will only be viewed by the therapist or therapist's supervisor at Mariposa, and will not be released to another party without your additional written consent. Mariposa needs to have your written permission to make and use these recordings for these purposes. We will keep all these materials in a safe location, and destroy them as soon as they are no longer needed.

Therefore, We are asking you to read and sign the following:

I, _____ consent to the recording of _____ therapy sessions for the purposes described above. This recording may be done by video and/or audio taping 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 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. If I choose to ask this, I will deliver a written statement to this effect to the therapist within 5 days following the viewing.

I give the therapist named below my permission to use the recordings of _____ for their own confidential use and professional purposes. I understand that the 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 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.