

Harmony Heals, Inc



CONSENT FOR AUDIO OR VIDEO RECORDINGS

Client Name: _____

Date of Birth: _____

Therapist: _____

I hereby grant permission to the therapist listed above to make audio and/or video recordings of one or more counseling sessions for which I am a participant. I understand that the tape will be used in training sessions or for therapeutic benefit to me and will only be reviewed by mental health professionals.

I further understand that I will receive advance notice of the taping and that it will be done with my full and complete awareness. Storage of the tapes will be in a locked file at the counseling office and will be erased upon my request.

Client Signature

Print Name of Client

Therapist Signature

Print Name of Therapist

Signature of Parent/Guardian

Print Name of Parent/Guardian

Date

