

AUDIO/VIDEO RECORDING CONSENT

I give my consent for therapy and/or assessment sessions of _____
whose date of birth is _____, to be recorded in the following manner(s):

Audio Recording

Video Recording

PURPOSE

I understand that these recordings are to be played only by Intuition Wellness team members. I understand that the recordings will be used exclusively for consultation, supervisory or learning purposes and will be handled in a sensitive manner that is compliant with HIPAA regulations.

EXPIRATION

Unless sooner revoked, this consent expires one year from date of authorization. I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Intuition Wellness Center, PLLC.

CONDITIONS

I further understand that Intuition Wellness Center, PLLC will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me what benefits there may be to signing this consent as it is intended as a means to assist the learning and strengthen the skills of the assigned therapist.

I UNDERSTAND THAT MY TYPED NAME BELOW REPRESENTS MY ELECTRONIC SIGNATURE.

Client Name

Signature of Client

Date

Guardian Name

Signature of Guardian

Date

Guardian Name

Signature of Guardian

Date