intuition
wellness center
LEARN. GROW. THRIVE.

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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 the assigned therapist with his/her consultants and supervisors. I understand that the recordings will be used exclusively for supervisory purposes by the assigned therapist 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 that there are many benefits 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

_____

Client Name *Signature of Client* *Date*

_____

Guardian Name *Signature of Guardian* *Date*

_____

Guardian Name *Signature of Guardian* *Date*