intuition wellness center
LEARN. GROW. THRIVE.

3131 N Country Club Rd, Ste 207
Tucson, AZ 85716
Phone: 520.333.3320
intuitionwellness.com

Audio/Video Recording Consent

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

- ☐ Audio Recording
- ☐ Video Recording

Purpose

I understand that recordings will be used solely for clinical consultation and supervision provided by members of the Intuition Wellness Center clinical team. All recordings will be protected in a manner that is compliant with HIPAA regulations and will be destroyed within 6 months from the time the recording was made. I further understand that recordings will not be made available to parties outside of Intuition Wellness Center unless required by law or with my written consent.

Expiration

I understand that I have a right to revoke this authorization, in writing, and without any negative bearing on the services that I receive at any time by sending written notification to Intuition Wellness Center, PLLC.

Conditions

The possible benefits of recording sessions have been fully explained to me, and I understand that Intuition Wellness Center, PLLC will not condition my treatment upon whether or not I give authorization for this requested disclosure. I have read carefully and fully understand the above statements and consent to the recording of my sessions for the stated purposes.

I UNDERSTAND THAT MY TYPED NAME BELOW IN THE SIGNATURE LINE REPRESENTS MY ELECTRONIC SIGNATURE.

In the case of a minor, all parents/guardians are required to print name, sign, date with time and complete highlighted areas and checkboxes for Audio/Video Recording Consent to be valid.

Relationship to Client: ☐ Self ☐ Parent ☐ Guardian

Your Printed Name

Your Signature

Date

Time

Relationship to Client: ☐ Parent ☐ Guardian

Your Printed Name

Your Signature

Date

Time