Arches Counseling and Trauma Treatment

CONSENT FOR RECORDING SESSION

I, _____ , hereby grant permission for Arches Counseling and Trauma Treatment to audio- and/or video-record my clinical sessions (or for _____, DOB _____ , for whom I am the parent/legal guardian) for the purposes specified below . At any time during a session, I/my child has the right to request that recording be stopped.

I grant consent to Arches Counseling and Trauma Treatment to record sessions for the following purpose(s):

_____internal use (including consultation, supervision and/or review with client).

_____teaching or professional trainings.

_____research.

_____use of anonymous transcripts in professional publications.

_____I do not consent to the recording of any sessions.

I understand that recordings permitted for internal use will be erased by Arches Counseling and Trauma Treatment . If I allow my recordings to be used for trainings, research or publication, then my recordings will be maintained in a protected manner. However, if I or my child is court-involved, then my recordings cannot be destroyed and will become part of the clinical file. I further understand that recordings will not be made available to third parties unless required by law.

I have carefully read and understand the above purposes. I have the right at any time to ask questions about how recordings are being used. I understand that I may revoke this consent at any time without any negative bearing on the services I or my child receives from Arches Counseling and Trauma Treatment.

_____	_____	_____
printed **client** name	**client** signature	date
_____	_____	_____
printed **guardian** name	**guardian** signature	date
_____	_____	_____
printed **clinician** name	**clinician** signature	date