PERMISSION TO VIDEO/AUDIO TAPING THERAPY SESSIONS

I/We____
consent to the

________video taping ________audio taping

of therapy sessions with Nicola Simmersbach, PsyD LMFT (MFT 33458).

I/We are aware of the presence of the

________video equipment ________audio equipment

and permit the use of all or part of the

________video tapes ________audio tapes

for the purpose of clinical review, consultation and certification.

_____ (initial) Our therapist and our review of our case to assist in our therapy.

_____ (initial) Our therapist's consultation with a clinical supervisor(s) including submission to the international Centre Excellence In Emotion Focused Therapy located in Ottawa, Canada.

Tapes are stored in a secure location and are taped over during subsequent sessions or destroyed upon completion of therapy.

In no way will the refusal to grant consent for this video taping effect my/our getting assistance for myself/ourselves. If at any time during the treatment process, we wish to stop the taping we may do so and still continue treatment.

______________________________ ______________________________
Signature Signature

______________________________ ______________________________
Printed Name Printed Name

_______________	_______________
Date	Date