GODMAN PSYCHOLOGICAL SERVICES, P.C.
Helping to navigate the mind
4231 Balboa Avenue #1256
San Diego, CA 92117
T: (619) 785-3665
info@godmanpsych.com

INFORMED CONSENT FORM FOR RECORDING TELEHEALTH SESSIONS

I, _____, give my permission for the: (circle all that apply)
(client)

Videotaping Audiotaping Discussion

of my EMDR session with on _____ with Dr. Carolyn Godman.
(date)

The purpose of this review is for the listed therapist's professional development in EMDR practice.

- I understand that confidentiality is of utmost importance and that my name will not be used in the presentation nor will identifying information be shared.

- I understand this presentation of my session(s) will be reviewed by Dr. Godman, with the involvement of an Approved Consultant in EMDR, and potentially other Consultants in Training, and/or Certification Applicants.

- I understand that any recording will remain in the control of the designated therapist at all times and will not be reproduced, unless by separate consent.

- I understand this release will be retained in my file unless I rescind it.

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• I understand that I can rescind this consent whenever I choose and that any recording of my session(s) will be discarded at my discretion and direction, after discussion with the above therapist.

• I understand that if I am involved, or likely to be involved, in litigation, I may choose to decline this request for any recording or use of my clinical material as caution against subpoena.

• I understand that there is no obligation to consent, with no penalty or consequence for declining, and I consent freely.

I do not want my face filmed: (initial here) _____

CLIENT NAME: _____ CLIENT DOB: _____

Signature of Client:_____ Date:_____

Signature of Parent/Guardian:_____ Date:_____

Relationship to Client:_____