

CONSENT TO VIDEO / AUDIO RECORD

Molly Bowen, Non-Licensed, Non-Certified Psychotherapist

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This document is for clients being seen by Molly Bowen, Non-Licensed, Non-Certified Psychotherapist (#097.0135130), practicing under the supervision of Leora E. Black, Ph.D., LCMHC, LMFT

In order to become fully licensed therapists, student therapists must work under the supervision of clinical supervisors who have access to recorded evidence of their work. In order to achieve this, the student therapist may periodically request to audio or video record counseling sessions.

Video and audio recordings are encrypted and are stored and viewed on a HIPAA secured website, Supervision Assist, which is used strictly for training purposes. They are not part of the client's clinical or medical records, and are automatically deleted one year after they are recorded (sooner if deleted manually). Clients have the right to view recordings of their therapy sessions. If you are interested in having access to recordings of your therapy sessions, please let your therapist know as soon as possible, so that site access can be granted and it can be ensured that recorded sessions are not deleted.

Clients are not required to be audio/videotaped and are under no obligation to have any sessions recorded. Clients can withdraw their permission at any time during or after the session. Access to services will not be affected by client's decision not to be audio/videotaped. You will never be video or audio recorded without awareness that a recording is taking place.

Supervision Team Who Would Have Access To Session Recording(s):

Antioch University Graduate Student Therapists: Molly Bowen, Emma DuBose, Jordan Newcomb, Miri Sampson

Counseling Connection Training Institute Clinical Site Supervisor: Leora Black, Ph.D, LMFT, LCMHC

Antioch University Student Supervisor: Samanda Bryant Hagan, LCSW-C, Ph.D. Student

Consent to Record Therapy Sessions

I do ☐ / do not ☐ (check one) grant permission to allow therapy sessions to be recorded and/or transcribed. I understand that only the individuals listed above will be permitted to review these recordings/transcriptions and that these recordings/transcriptions will be subject to standards of confidentiality ethics and laws. I understand that I may withdraw this permission to record and/or transcribe at any time. I understand that my recorded therapy sessions will be deleted within one year of the recording occurring.

(Client or Parent/Guardian Signature)

(Date)

(Client or Parent/Guardian Signature)

(Date)

(Client or Parent/Guardian Signature)

(Date)

(Molly Bowen, Rostered)

(Date)