Permission to Video/Audio Tape Counseling Sessions

**In order to improve my, or other therapist’s, counseling skills, I typically record sessions. If you are comfortable with this, I need your written permission. You are free to say no. If you agree, you may, at any time, change your mind and we can stop recording.**

**I give permission for Elizabeth Johnston, LICSW to record our counseling sessions for the following use.**

**Circle and initial the option agreeable to you.**

**\_\_\_\_\_\_\_\_\_\_\_\_ 1). Only for Elizabeth Johnston’s review outside of sessions.**

**\_\_\_\_\_\_\_\_\_\_\_ 2). For Elizabeth Johnston’s use in peer supervision meetings.**

**\_\_\_\_\_\_\_\_\_\_ 3). For Elizabeth Johnston’s use in consulting with referring, or follow-up therapist.**

**\_\_\_\_\_\_\_\_\_\_\_4). All of the above.**

**I understand that my confidentiality will be protected.**

**Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(signature)**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(print)**

**Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(signature)**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(name)**

**Elizabeth Johnston, LICSW \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**