

Informed Consent Document for
Recording Therapy Clients
PSY 642-500

I, _____, hereby acknowledge that I agree to allow my therapist, _____, to videotape or audio tape our therapy sessions for use in his or her graduate therapy class.

I understand the following points:

- _____ 1. I give my permission (consent) to allow my therapy sessions with my therapist to be recorded, either by videotape or audiotape.
- _____ 2. I understand that these recordings will be shared with the psychotherapy class that is supervised by Dr. Rick Grieve, who is not the normal supervisor for my therapist.
- _____ 3. I understand that confidentiality also applies to the materials presented in this class, and understand that the recorded therapy session(s) will be held in confidence.
- _____ 5. I understand that I may contact Dr. Grieve at (270) 745-4417 if I have concerns that cannot be resolved with my therapist.

Client Signature

Date

Therapist Signature

Date