Authorization Release for Permission to Record and/or Photograph Therapy

Material for ________________________________ (please print client name)

Some information is best portrayed visually rather than a written record alone when using expressive therapies. Photographs of art and play creations and videos of some types of sessions are used for review of progress with clients as well as consultation, training, and research. Only content deemed to be helpful by your therapist will be documented in these ways and your written consent is required to make any photographic or video recordings. The recording of sessions and photographs of work will likely enhance the effectiveness of your treatment, but is not required. You may decline to have sessions recorded or photographed. You may also specifically designate how you wish such records to be used. All videos and photos will be kept in a secured location and destroyed when no longer being used for the purposes you specify below.

Confidentiality For any of the uses agreed to below, the strictest confidentiality will be maintained, and there will be no sharing of the recorded material beyond the limits specified in this document. Except for voices and/or images on the recording, identifying information will be withheld or altered to protect your identity. Mental health professionals who may view or hear recorded material of your session (if permission is given here) are bound by law and by code of ethics to the same obligation to protect your confidentiality.

Both Video and Photo (initial below)	**Photo only** (initial below)	**How my or my child's recorded material may be used:**
		Session Review Only The recording or photo may be reviewed privately by your therapist and his/her supervisor to inform treatment decisions. It may also be reviewed in session by the client and/or client's parent or guardian who is active in the child's treatment when helpful for therapeutic goals. Items will be destroyed when no longer needed for treatment.
		Consultation The recording may be shared with a clinical consultant who has been engaged to provide expert clinical consultation regarding the therapy process. This consultation is a vital source of professional development and accountability; it provides additional clinical expertise as a resource to your treatment and increases its effectiveness.
		Training A brief recording excerpt or photograph may be used by your therapist in the training of other therapists to demonstrate concepts and techniques of treatment. No identifying information, beyond the content of the video or photo and general clinical details, will be shared.

Other Conditions (specify):

Client Name:_________________________________-

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Freedom to withdraw consent We understand that we may withdraw previously granted consent at any time without giving a reason by contacting our therapist and requesting in writing to do so, and that this withdrawal will not affect our treatment or relationship with our therapist in any way.

My signature below indicates that I/we affirm that I/we have both the legal authority to grant permission and willingly grant permission to Upswing Counseling to video record/ photograph our child, parent, and family therapy sessions for the limited purposes we have indicated on page one of this document.

Parent/Guardian/Child 12+__________________________________ Date _________________

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Parent/Guardian/Child 12+ _________________________________ Date _________________

Witness ____ Date _________________