(Therapist’s name & address here)

Informed Consent to Videotape and Release Information Via the Internet

In order to provide a high standard of care and to enhance the quality of your treatment it is common for clinicians to participate in consultation and training groups within their discipline. This consultation involves ( name of therapist) sharing a brief overview of your treatment including your presenting problem. No personal identifying information is disclosed in order to protect your confidentiality. By initialing the scenario(s) below and then signing, I give my consent to allow my counseling sessions with (name of therapist) to be electronically recorded for consultation and training. I understand that any other therapist who watches this recording is under the same confidentiality requirements as my therapist. Further, I understand that if by chance any therapist knows me socially or personally, he/she will immediately leave the session and will not observe, seek or be given any information about my situation.

I understand that I may request the electronic recording to be discontinued at any time—either temporarily or permanently.

I understand that (name of therapist) may retain electronic recordings per professional standards, but is in no way required to retain any electronic recordings produced in this process. I authorize (name of therapist) at her /his sole option, to erase or otherwise destroy any and all recordings after they have been used for the intended purpose, or at any other time, whether they have been used or not. I understand that these recordings are not part of my treatment record.

I understand that my decision about whether or not to permit electronic recording will have no impact on the treatment I will receive. I understand that I may withdraw this consent at any time.

 I understand that other therapists cannot in any way be held responsible for what occurs in our therapy sessions or the outcome of these sessions. I understand that my therapist (name of therapist)is solely responsible for the conduct of our therapy sessions.

I give permission for (name of therapist), to record our therapy session(s) for the following use.

1. For review, via Zoom a HIPAA compliant web and video conferencing platform suitable for use in healthcare, by ( name of therapist) and an EFT supervisor/consultant.

\_\_\_\_\_ \_\_\_\_\_

1. For review, via Zoom a HIPAA compliant web and video conferencing platform suitable for use in healthcare, by ( name of therapist) in EFT supervision/ consultation group(s). \_\_\_\_\_ \_\_\_\_\_
2. For review, via Zoom a HIPAA compliant web and video conferencing platform suitable for use in healthcare, by my therapist’s EFT supervisor/consultant in order to receive further training in supervising/consulting. \_\_\_\_\_ \_\_\_\_\_

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

 (Signature) (Date)

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

 (Print)

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

 (Signature) (Date)

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

 (Print)

Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_