



Susan Blank, LPC, NCC

PERMISSION TO VIDEOTAPE THERAPY SESSIONS

We, _____ and _____ consent to the videotaping of therapy sessions with Susan Blank, LPC, NCC.

We are aware of the presence of the video equipment and permit the use of all or part of the video tapes for the purpose of: (please initial below the type of use you are permitting)

_____ (initial) Our therapist to assist in our therapy for educational review.

_____ (initial) Our therapist’s consultation with a clinical supervisor(s) and/or training group for the purpose of acquiring certification in Emotionally Focused Therapy.

The videotapes are kept completely confidential and all professionals who view the tapes are under therapist confidentiality.

In no way will the refusal to grant consent for this video taping effect my/our getting assistance for myself/ourselves. If at any time during the treatment process, we wish to stop the taping we may do so and still continue treatment. **I also understand video or audio recordings are not a part of my permanent record.**

Signature

Signature

Printed Name

Printed Name

Date

Date

Therapist’s Signature: _____

Therapist’s Printed Name: _____

Date: _____