Jo Raphael, LCSW, ACSW, BCD
6100 Lake Forrest Dr., Suite 450, Sandy Springs, GA 30328
Phone: 404.291.9181

PERMISSION TO VIDEOTAPE THERAPY SESSIONS

I/We_____consent to the videotaping of therapy sessions with Jo Raphael, LCSW, ACSW, BCD.

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 clinical supervisees and/or training group for the purpose of acquiring certification in Developmental Individual-difference Relationship/Floortime based therapy and/or the Play Project.

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/s

_____
Printed Name/s

_____
Date

Therapist's Signature: _____

Therapist's Printed Name: _____

Date: _____