CONSENT TO RECORD SESSIONS

I, (We) _____ consent to allow _____ to
(Therapist)
digitally record my/our conjoint psychotherapy sessions. My therapist has explained the commitment to improving the practice of therapy and how the recordings are to be used.

I/We understand that the use and viewing of these digital recordings in whole or part is strictly limited to the following: (please initial)

_____ Review by my therapist to optimize the quality of my/our care

_____ Use by my therapist for the purpose of professional consultation about treatment provided at LIFE.

_____ Use by my therapist for the purpose of supervision and care management with other professional therapists. Each therapist is bound by the same rules of confidentiality and professional boundaries as my treating therapist.

I/We understand that our names will never be disclosed, and that only therapists who do not know us will be allowed to view these recordings. We further understand that the recordings are not part of our permanent medical record and that our therapist will destroy each digital recording after it has been used for its intended purpose.

We understand that either of us may withdraw our consent at any time.

Signature: _____ (Date) _____

Signature: _____ (Date) _____

Therapist: _____ (Date) _____