PERMISSION TO VIDEOTAPING THERAPY SESSIONS

I/We _____ consent to the videotaping of therapy sessions with Jill Smith & Associates.

I/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's educational review to assist us in our therapy.

_____ (initial) Our therapist's consultation with a clinical supervisor(s) and/or training group to assist us in our therapy.

In no way will the refusal to grant consent for this videotaping 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 part of a permanent record.

_____	_____
Signature	Signature
_____	_____
Printed Name	Printed Name
_____	_____
Date	Date

Therapist's Signature: _____

Therapist's Printed Name: _____

Date: _____