

Authorization Release for Permission to Record and for Use of Recorded Material

Video and audio recording are commonly used for consultation, training and research in therapy. In order to record your session I need your written consent. The recording of sessions will likely enhance the effectiveness of your treatment, but is not required. You may decline to have sessions recorded.

Confidentiality For any of the uses agreed to below, the strictest confidentiality will be maintained, and there will be no sharing of the recorded material beyond the limits specified below. Except for your first name and your voice and/or image on the recording, there will be no information that could identify you. The recording will never knowingly be shared with anyone who knows you. Mental health professionals who may view or hear recorded material of your session (if permission is given here) are bound by law and by code of ethics to the same obligation to protect your confidentiality. Except as noted below, the existence of this recording will not be discussed with anyone at any time.

Initial **How the recorded material may be used**

_____ **Session Review Only** The recording may be reviewed privately by Brianna Finney, MA prior to the subsequent session. It will not be kept beyond the subsequent session and no recording will be kept beyond the conclusion of treatment.

_____ **Consultation** The recording may be shared with a clinical consultant who has been engaged to provide expert clinical consultation regarding the therapy process. This consultation is a vital source of professional development and accountability; it provides additional clinical expertise as a resource to your treatment and increases its effectiveness.

_____ **Training** A brief recording excerpt may be used by Brianna Finney, MA, to receive additional expert training, and to aid in the training of other therapists, to demonstrate concepts and techniques of treatment. Absolutely No information which could identify you will be shared.

Other Conditions (specify): _____

Freedom to withdraw consent. We understand that we may withdraw granted consent at any time.

Authorization to Contact Clients Via Text Message, Voice Message, or Email

Text message and email will be primarily used for scheduling/rescheduling purposes. If a client initiates session content via email or text message, Brianna Finney, MA may provide a brief response, otherwise she will return your message with a phone call if it requires a longer discussion. Please note: the security of communications of any kind by email cannot be guaranteed, and it is not encrypted, secure, and may be accessed by third parties. Any emails received from patients will become a part of that person's permanent file. Please check your communication preference(s), check all if they apply.

-- Text Message -- Voice Message Preferred Contact # _____

-- Email Preferred Email _____

We give our permission to Brianna Finney, MA to video/audio record our therapy sessions for the purposes indicated above, and to contact us via the specified communication(s) method.

Client _____ Date _____

Witness _____ Date _____
Brianna Finney, MA