**INFORMED CONSENT TO RECORD/VIDEO THERAPY SESSION**

***PLEASE READ ALL OF THE BELOW INFORMATION CAREFULLY.***

As part of the ongoing professional development and training requirements, provisional psychologists and psychologists are required to engage in supervision of their psychological practice with other psychologists on a regular basis. As part of this process recordings of sessions may be used for peer review, to promote learning, and demonstrate competency, which allows for quality assurance and meeting supervision and training requirements.

By signing this form, you consent to your session(s) being recorded and understand the following:

1. My clinician will ask for my permission before recording any session.
2. I understand I can request the recording be stopped at any time during the session if I change my mind.
3. I understand I can withdraw consent at any time.
4. My clinician will only use the recording for the purposes of professional supervision and will not share the recording for any other purpose.
5. I understand my clinician will follow the privacy laws and code of ethics that are specific to our country of origin.
6. All copies of the recording will be deleted in a secure manner following viewing with my supervisor.
7. The supervisor who will be reviewing my direct observation is:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing below, you are stating that you have read and understood the Informed Consent Video Recording and you are permitting \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to video/audio record your session(s) and review the video/audio file(s) for supervision purposes. Your consent can be revoked at any time by contacting your clinician directly.

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature: ­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: ­­­­­­­­­­­­­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician Signature: ­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: ­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_