AUTHORIZATION TO RECORD

I give full and free consent to my counselor _____
Name & Address of Counselor

_____ to make audio/video recordings of our counseling sessions. It is my understanding that my counselor, a graduate candidate in counseling at Western Seminary, will be reviewing recordings on occasion with a faculty supervisor, other students, and professional peers. It is my further understanding that all material will be treated with full professional confidentiality and that any identifying data will be appropriately modified where possible.

All recordings are part of the client file and will be stored in a secure location. These recordings may be erased or destroyed at any time following recording, not to exceed 180 days thereafter. This authorization may be revoked in writing at any time, except to the extent that disclosure has already been made in good faith reliance upon this release.

Client's Signature _____

Date of Birth _____ Date _____

If client is a minor, Signature of Parent or Guardian _____

Counselor's Signature _____

Date _____