AUTHORIZATION TO RECORD

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

____ to make audio/video tapes of our counseling sessions. It is my understanding that my counselor, a graduate candidate in counseling at Western Seminary, will be reviewing tapes 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 tapes 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 on this release.

Client's Signature ____

Age _________ Date ____________________________

Counselor's Signature ____

Date ____________________________