SOUTHWEST FAMILY
GUIDANCE CENTER & INSTITUTE

Recording Consent Form

CLIENT FIRST NAME	
CLIENT LAST NAME	
GUARDIAN FIRST NAME	
GUARDIAN LAST NAME	
RELATION TO CLIENT	
EMAIL ADDRESS	
NAME OF THERAPIST	

Choose the applicable option below:

- ◯ I give permission to video record therapy sessions involving myself, my child, and/or my family for the duration of our participation in therapy services at SWFGC.
- ◯ I give permission to audio record therapy sessions involving myself, my child, and/or my family for the duration of our participation in therapy services at SWFGC.
- ◯ I decline to have therapy sessions involving myself, my child, and/or my family video/audio recorded.

By signing below I authorize Southwest Family Guidance Center to audio/video record sessions for the duration of our participation in therapeutic services. I understand that any recordings created will be used for clinician training and professional development purposes only, and in all such instances, confidentiality is carefully maintained. The therapist will inform you prior to recording a session.

SIGNATURE

DATE