Consent for digital video or audio recording

I, _____ hereby authorize
(Print Client's Name)

_____ to record by ___ audio ___ video, our
(Counselor's Name)

counseling sessions for supervisory purposes. I understand that these recordings may be viewed by my counselor's supervisor and my counselor's professional colleagues in small group (i.e. less than 10 people) or individual supervision for educational and consulting purposes for up to 6 months after the date this form is signed, after which the recording will be deleted.

I understand that I may revoke this consent* at any time except to the extent that action based on this consent has been taken, or if this form has been used to obtain insurance coverage for services provided. This authorization is fully understood and is made voluntarily on my part.

_____ Date _____
(Signature of Client or Legally Responsible Person)

_____
(Witness)

*In order to revoke consent, please contact Department of Addictions and Rehabilitation Studies, East Carolina University (252) 744-6300