

**SOUTH CAMPUS
909 E. Wilmette Road
Palatine IL 60074
847-359-8300**

CONSENT TO VIDEO/AUDIO TAPE

I authorize the video/audio taping of _____ in psychotherapy sessions. I understand that these tapes will be used as a part of my child's treatment plan and by my child's therapist for clinical supervision and teaching/training purposes with other therapist/therapy students. I understand that although my child's likeness will be visible, his/her full name will not be used and all observers will have a professional obligation to treat the material confidentially. I agree to the use of this tape in the following way (s):

Please check (X) as appropriate:

For formal supervision and/or training within South Campus, Connection Day School, Counseling Connection.

For formal supervision and/or training at the trainee's home School,

(School Name)

For formal supervision and/or training at the following location _____ with _____.

(Supervisor)

This consent will remain valid for one year (unless withdrawn sooner), and may be reauthorized only with a new consent.

Upon expiration of this agreement, I request that:

The tape be destroyed

The tape be maintained in a confidential library for internal training at SC, CDS, CC facilities and will not require additional signed consent for its use. Any other use of this tape from the library will require a signed consent for its specific use.

This consent is limited to only the information designated above, which will be used only by the individual(s), agencies and school(s) named herein. The purpose of this consent is to assist in providing treatment, training and supervision. I understand that I have the right to revoke this authorization at any time by submitting such a request in writing. I also understand that my refusal to consent to the use video/audio taping will not interfere with my child's treatment or education in any way.

Signature of Parent

Date

Signature of Student (if 12 years or older)

Date

Witness

Date