AUTHORIZATION TO AUDIOTAPE AND VIDEOTAPE

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize video recording of my evaluation and treatment sessions with YOUR NAME.

It has been explained to me that my treatment video recordings will be viewed or heard by a consultant, Dr. Sandy Capaldi, at the Center for the Treatment and Study of Anxiety at University of Pennsylvania, and by members of Dr. Capaldi’s consultation group for purposes of clinical consultation. All members of the consultation group are mental health professionals who adhere to the same privacy, confidentiality, and HIPAA guidelines.

My treatment video recordings will be saved in an encrypted folder that is password protected. Video recordings will be deleted from the folder when treatment terminates.

It has been explained to me that my therapist may not refuse to treat me if I refuse to sign authorization.

It has been explained to me that I may revoke this authorization at any time, in writing, and that following such revocation no further video recording of my treatment will occur.

This authorization will expire in twelve (12) months from the date of execution.

***I hereby release my therapist and his/her consultant from any claims and any liability arising in connection with use of my treatment videotapes or audiotapes: 1) as part of standard treatment and consultation procedures; and 2) for the additional purposes I have authorized above.***

I give this authorization voluntarily and with full understanding of its nature.

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Signature of Patient 14 years or older Date

or Personal Representative

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Signature of staff member obtaining consent Date