

## Audio/Video Recording Release Form

**I voluntarily agree to have my therapy sessions audio and/or video recorded.** I understand that I will receive service whether or not I agree to audio or video recording of sessions. I understand that I may request that specific sessions or parts of sessions not be recorded or that they be erased, and that I may at any time request to listen to a recording. These recordings are **CONFIDENTIAL** and will only be used by Myron Walters and his supervisor(s), for improving the client's therapy.

_____	_____
<b>Client</b>	<b>Date</b>
_____	_____
<b>Parent (if client is a minor)</b>	<b>Date</b>
_____	_____
<b>Parent (if client is a minor)</b>	<b>Date</b>
_____	_____
<b>Therapist</b>	<b>Date</b>