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.

_____ _____

Client **Date**

_____ _____

Parent (if client is a minor) **Date**

_____ _____

Parent (if client is a minor) **Date**

_____ _____

Therapist **Date**

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