Ben Trelease, LMHC

Counseling for couples, families and individuals

PERMISSION TO VIDEO RECORD THERAPY SESSIONS

I/We_____ consent to the video recording of therapy sessions with **Ben Trelease, LMHC**.

I/We are aware of the presence of the video equipment and permit the use of all or part of the video recordings for the purpose of: (please initial below the type of use you are permitting)

_____ (initial) Our therapist and our review of our case to assist in our therapy.

_____ (initial) Our therapist's consultation with a clinical supervisor(s).

_____ (initial) Other use (specify):_____

All recordings remain the exclusive property of **Ben Trelease** and are not considered part of the client's file. Recordings will be destroyed at the conclusion of the therapeutic relationship or at any time at the request of the client.

In no way will the refusal to grant consent for this video recording effect my/our getting assistance for myself/ourselves. If at any time during the treatment process, we wish to stop the recording we may do so and still continue treatment.

_____ _____
Signature Date

_____
Printed Name

_____ _____
Signature Date

_____
Printed Name

_____ _____
Ben Trelease Date

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