AUTHORIZATION TO RECORD PSYCHOTHERAPY SESSIONS

My therapist is a doctoral student & trainee enrolled in a doctoral psychology program and under the supervision of a licensed professional at the Bay Area Trauma Recovery Clinical Services (BATRCS). I understand that by authorizing the use of the recordings for:

- "Supervision by direct supervisor" my therapist will be reviewing these recordings with his or her clinical supervisor to ensure I am receiving the best treatment possible and for training purposes.
- "Clinical training at the BATRCS" my therapist will be reviewing these recordings with her or his trainers and fellow therapists-in-training at the BATRCS as part of their regular training.
- Uses for other purposes need to be clearly specified & authorized before such use may occur.

I understand that I **do not have the right** to refuse to sign this authorization for audio recording if I wish to receive services at Bay Area Trauma Recovery Clinical Services, as it is required for all intake sessions, individual sessions, and group sessions. I understand that I **do have the right** to refuse video recording and that my refusing of video recording would have no consequences on my ability to receive services at the BATRCS. I **do have the right** to refuse the recording of telehealth (video or phone) therapy sessions.

I, *(please print full name of client)* _____, voluntarily authorize my therapist, *(please print name of therapist)* _____, to record my psychotherapy sessions using the following means:

☐ Audiotape _____ *(Client's Initials)*

☐ Videotape _____ *(Client's Initials)*

I authorize the use of these confidential audio or video recordings for the following purposes:

☐ Supervision by direct supervisor _____ *(Client's Initials)*

☐ Clinical training at the BATRCS _____ *(Client's Initials)*

☐ Other *(describe)*: _____ _____ *(Client's Initials)*

This authorization shall remain for the duration of therapy services at BATRCS. It is agreed that (unless I otherwise authorize it in writing), all of the contents of any recording of my therapy sessions will be fully erased or destroyed as soon as it has been used, and at the latest by the end of my therapists' training year at the BATRCS, in the month of July of the year 2021. They will also be maintained in full confidentiality together with my other psychotherapy records until their destruction.

Upon my request, my therapist will provide me with a timely copy of this authorization.

Client's signature: _____ *Date:* _____

Therapist or witness: _____ *Date:* _____