



AUDIOTAPING AND VIDEOTAPING CONSENT FORM

Name of Client (Child/Youth) _____ DOB _____

Name of Parent/Guardian _____

Madison Youth & Family Services' (MYFS) Outpatient Clinic utilizes graduate student interns as a part of our clinical staff to provide treatment to individuals, parents, and families. The quality of training and service delivery by our clinical interns is best ensured by audio and video taping of treatment sessions. My signature on this form provides acknowledgement of this policy and either permits consent or declines audio and/or videotaping of therapy sessions.

If permitted, taped sessions will be reviewed by the clinical intern and his/her supervisor as a part of regular supervision meetings. Tapes may be reviewed by other MYFS clinical staff members for the purpose of further feedback and training. Tapes may also be reviewed directly with clients if requested or if the clinical intern deems it as potentially helpful in the overall therapeutic process. Tapes are generally erased immediately following a supervision meeting and will be erased by the time treatment is terminated. Audiotaping and/or videotaping are not a required part of treatment at MYFS. Declining to allow taping will not impact a client's eligibility to receive treatment services at MYFS.

Please check the appropriate box(es) and initial:

- _____ I consent to allow sessions between my child and his/her therapist to be audiotaped
- _____ I consent to allow sessions between my child and his/her therapist to be videotaped

My consent is understood to also include the following minor children if/when family sessions are conducted:

_____ I decline to allow sessions between my child and his/her therapist to be taped

Signature:

Parent/Guardian: _____ Date: _____

Staff Signature: _____ Date: _____