**MEDIA CONSENT FORM: CLIENT AUTHORIZATION FOR RELEASE OF AUDIO/VIDEO**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize YOUR COMPANY NAME to: [Please print name(s) of client(s)]

**Check all applicable:**

☐Take my picture ☐Video tape me

☐Interview me ☐Audio tape me

☐Use my testimonial for marketing purposes ☐Observe me

**For the purpose of check all applicable:**

☐Therapy with future clients to assist in the therapeutic process (requires a HIPAA Authorization)

☐Videotape client/couple/family for use in therapy self-viewing

☐Videotape for use in training (requires a HIPAA Authorization and your identity will not be provided to viewers)

☐Other [Specify] (requires a HIPAA Authorization) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I understand this authorization is valid for, check one:**

☐For self viewing during session - \* *video will then be erased at end of session or termination of therapy*

☐A limited time of 60/90/120 days (Circle One) - \* *video will then be erased on Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

☐An unlimited time for the exclusive use of YOUR COMPANY NAME

I also understand that I may cancel this authorization at any time, by submitting my request in writing. This Authorization was not obtained as a prerequisite to receiving care, and I give this authorization of my free will and agree to hold YOUR COMPANY NAME, its officers, agents and principals harmless from any damages or injury resulting from use of the media consistent with this Authorization.

I agree to allow the listed items above be taken and utilized without financial remuneration, and I hereby release YOUR COMPANY NAME from any future claims as well as from any liability arising from the use of the media.

Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician’s Printed Name & Credentials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_