**Consent for Videotaping and Audiotaping**

**Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (parent/guardian), give Clifford Beers Clinic (CBC) permission to audio/videotape me and members of my family (child/family members) for purposes of (check all that apply):

* Professional internal training of CBC staff and interns (e.g., supervision, case presentation)
* Video or voice recording of me and/or interview me
* Perform recorded work and to edit/ combine with others’ work for presentation
* Professional external clinical consultation regarding my child and/or family
* Other reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* I understand that I am not required to sign this form in order to receive services from CBC.
* I understand the audio/videotape will be treated as confidential information.
* I understand the audio/videotape will not be part of any records kept by CBC, but this signed consent form will be part of the record.
* I understand that I may revoke this videotape consent at any time by notifying CBC staff in writing and the revocation will be effective on the date notified (except to the extent action has already been taken based on my earlier consent).

By signing below, I acknowledge that I have read and understand this consent form.

Parent/Guardian Name (Please print)

Parent/Guardian Signature Date

CBC Witness Name (Please print)

CBC Witness Signature Date