Tele-Pyschiatry & Tele-Medicine &
Tele-Substances Abuse Treatment

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AUDIO/VIDEOTAPE RECORDING CONSENT FORM

I understand that the counseling sessions provided to, _____
(First & Last Name of Client)

by, _____ will be recorded
(First & Last Name of Counselor/Therapist)

via **audio/video tape** in order to supervise and evaluate the counselor/therapist's effectiveness. These recordings would also clarify any possible questions regarding care delivery. The audio/video recordings are part of the case file. I further understand that confidentiality and safety of all recorded sessions will be maintained. Only authorized Pathways Staff will have access to the recorded sessions. I understand that other DGmed, Inc. counselor trainees may review the recorded sessions for instruction or clinical supervision purposes only.

I understand that I am not required to consent to recoding and that if granted, I may revoke this consent in writing at any time. My signature below indicates my understanding of this form and my consent for recording of sessions:

I consent to the audio/video recording: ☐ **YES** ☐ **NO**

_____ _____
Client's Signature Date

_____ _____
Parent/Guardian's Signature (If client is a minor) Date

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Gloria O'Neill
President & CEO
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This notice accompanies a disclosure of information concerning a client that might be in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.