PERMISSION TO RECORDING THERAPY SESSIONS

I/We_____
consent to the recording of therapy sessions with __Silvia DaRe, LMFT.
I/We are aware of the presence of the recording equipment and permit the use of all or part of the recording for the purpose of: (please initial below the type of use you are permitting)

_____ (initial) Our therapist to assist in our therapy for educational review.

_____ (initial) Our therapist's consultation with a clinical supervisor(s)

In no way will the refusal to grant consent for recording effect my/our getting assistance for myself/ourselves. If at any time during the treatment process, we wish to stop the recording we may do so and still continue treatment.

_____	_____
Signature	Signature
_____	_____
Printed Name	Printed Name
_____	_____
Date	Date

Therapist's Signature: _____

Therapist's Printed Name: _____

Date: _____

Silvia DaRe, Licensed Marriage & Family Therpist (LMFT)
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