Julander
Inner Strength & Potential

Authorization for session(s) to be videotaped

1. **Client's Name:** _____
   First Name Middle Initial Last Name

2. **Date of Birth:** _____/_____/_____
3. **Date authorization initiated:** _____/_____/_____
4. **Authorization and Signature:**

I hereby give permission for therapy sessions to be videotaped for the sole purpose of receiving clinical feedback from my clinical supervisor and/or consultant. This authorization is completely voluntary and may be revoked at any time.

After the session is reviewed by a clinical supervisor and or consultant and feedback is given to the therapist, the video file will be deleted.

Client Signature:_____ Date:_____

*Guardian Signature:_____ Date:_____

* If client is between the ages of 12-17, the signature of both minor and parent/legal guardian is necessary.

Witness Signature:_____ Date:_____