Kate Halliday, LCSW
Newfield, NY14867
607-279-5439
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CONSENT FOR VIDEOTAPE RECORDING

I _____, consent to the videotaping of my therapy sessions with Kate Halliday.

I understand that these recordings will be used to further the quality of my therapy by enabling Kate to self-supervise, and may also be shown to professional colleagues in research, supervision, training and consultation.

I understand that pursuant to privacy laws, recorded therapy sessions will be stored on disks, not in a computer, and will be treated like other confidential documents. I may ask for a copy of the recording of any session.

I release Kate Halliday from any liability or claim in connection with these videotaped recordings for the above stated purposes. I understand that I shall receive no financial compensation for the use of these videotaped recordings. I further understand that upon my request, the recordings in question will be destroyed.

_____ _____
Client Signature Date

_____ _____
Therapist Signature Date