

**Boulder Family Counseling P.L.L.C.
Susan Caso, MA, LPC
2935 Baseline Road
Suite 302
Boulder, CO 80303**

Informed Consent to Videotape and Release Information

By initialing the scenario(s) below and then signing, I give my consent to allow my counseling sessions with Susan Caso, MA, LPC to be electronically recorded. For those scenarios initialed that are applicable, I further consent that she may share this recording with other therapists in her consultation group and/or for teaching and/or training and/or research purposes. If applicable, I understand that any other therapist who watches this recording is under the same confidentiality requirements as my therapist. Further, I understand that if by chance any therapist knows me socially or personally, he/she will immediately leave the session and will not observe, seek or be given any information about my situation.

I understand that I may request the electronic recording to be discontinued at any time—either temporarily or permanently.

I understand that Susan Caso may retain electronic recordings per professional standards, but is in no way required to retain any electronic recordings produced in this process. I authorize Susan Caso at her sole option, to erase or otherwise destroy any and all recordings after they have been used for the intended purpose, or at any other time, whether they have been used or not. I understand that these recordings are not part of my treatment record.

I understand that my decision about whether or not to permit electronic recording will have no impact on the treatment I will receive. I understand that I may withdraw this consent at any time.

If applicable, I understand that other consultants/therapists cannot in any way be held responsible for what occurs in our therapy sessions or the outcome of these sessions. Further, the consultation and/or teaching, and/or training or research is a service to me and that Susan Caso is solely responsible for the conduct of our therapy sessions.

I give permission for Susan Caso, to record our therapy session(s) for the following use. (Both of you must initial the options that are agreeable to you.)

- 1) Only for review by Susan Caso. _____

- 2) For review by Susan Caso and an EFT consultant.
Name of consultant: Patti Swope, RN, LMFT _____

3) For use in EFT consultation groups. Names of therapists in this group(s) _____

4) For use in teaching graduate students or therapists. _____

5) For research in EFT. _____

6) For use in professional training workshops. _____

7) All of the above. _____

Client: _____
(Signature) (Date)

Name: _____
(Print)

Client: _____
(Signature) (Date)

Name: _____
(Print)

Therapist: _____