AGREEMENT TO RECORD THERAPY SESSIONS FOR REVIEW/ CONSULTATION

I _____, give permission for Dr. Jennifer Rubolino, LMHC, NCC to record our counseling sessions. The purpose of recording sessions is to improve Dr. Rubolino's quality of care, understanding and embodiment of the EFT and AEDP models, and/or her certification in the models. Viewers of our recorded sessions may include Dr. Rubolino herself, and/or her clinical supervisor. Recordings will be disposed of/destroyed by Dr. Rubolino and/ or her supervisor in a manner consistent with applicable laws and rules immediately once they have been reviewed and our recorded material held confidential.

I understand that the recordings of the session(s) and the consultant's feedback to Dr. Rubolino will be kept private and confidential. I understand that no names or identifying information other than what is on the recording will be provided to anyone.

I consent to have the recording of our session(s) be viewed by a representative of the International Centre for Excellence in Emotionally Focused Therapy (ICEEFT), and/or a representative of the AEDP Institute. I understand that this recording will be kept confidential and viewed only by a Certified EFT/ AEDP therapist/supervisor as part of the ICEEFT / AEDP Certification procedures. The ICEEFT / AEDP representatives will also take responsibility for destroying the recordings after viewing them.

I understand that I can request to stop recording at any time. I understand that I can decline this authorization the record and am signing this of my free will as I understand it will be helpful to my treatment. I understand if I do not sign it that we will not be penalized in any way.

Signed:
Client (s) Name:

_____