

New Connections Academy  
**Consent to Audio/Video Tape**

I authorize the taping of my child (print name), \_\_\_\_\_  
in psychotherapy sessions. I understand that these tapes will be used as a part of my child's treatment plan,  
and by my child's therapist for clinical supervision and teaching/training purposes with other therapists and  
student therapists. I understand that although my child's voice may be audible and/or likeness may be  
visible, his/her full name will not be used, and all listeners/observers will have a professional obligation to  
treat the material confidentially. I agree to the use of this tape in the following way(s) – please check (X) as  
appropriate:

\_\_\_\_\_ For formal supervision and/or training within New Connections Academy and our parent company,  
Counseling Connection.

\_\_\_\_\_ For formal supervision and/or training at the student therapist's graduate program.

Program Name: \_\_\_\_\_

\_\_\_\_\_ For formal supervision and/or training at a specified site (from the 4 listed above).

Name of Site(s): \_\_\_\_\_

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This consent will remain valid for one year from signature (unless withdrawn sooner), and may be  
reauthorized only by signing a new consent form. Upon expiration of this agreement, I request that – please  
check (X) as appropriate:

\_\_\_\_\_ The tape be destroyed.

\_\_\_\_\_ The tape be maintained in a confidential library for use as a training tool at New Connections  
Academy, and Counseling Connections, and will not require additional signed consent for its use. Any other  
use of this tape will require signed consent for its specific use.

This consent is limited only to the information designated above, and will be used exclusively by the  
individual agencies and schools named herein. The purpose of this consent is to assist in providing treatment  
for your child; and training and supervision for student therapists. I understand that I have the right to revoke  
this authorization at any time by submitting such a request in writing. I also understand that my refusal to  
consent to audio/video taping will not interfere with my child's treatment, or education, in any way.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Student (if 12 years or older)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date