Charles M. Iker,
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Informed Consent to Audiotape or Videotape Treatment

Video and audio recordings are commonly used for consultation, training and research in mental and behavioral health treatment. The recording of sessions will likely enhance the effectiveness of your treatment. For example, your psychotherapist can monitor and accelerate the therapy process, in collaboration with supervisors and consultants.

In order to record your session/appointment, we require your written consent. This is completely voluntary, and your treatment will not be affected if you decide not to consent.

I understand that Charles M. Iker, LCSW will take all reasonable efforts to ensure that such recordings remain confidential and are used or disclosed only as allowed herein or as required by law.

I understand that such recordings are deemed separately kept psychotherapy notes and are not part of my permanent health record. This also means Charles M. Iker, LCSW has the sole and exclusive rights to its viewing, display, and erasure and I acknowledge that all recordings become the sole and exclusive property of Charles M. Iker, LCSW.

I understand that I can request that any recording be turned off at any time, and I may withdraw this permission to record at any time.

I, the undersigned, give my full consent to the uses of these recordings as indicated by initialing below:

_____The recordings can be reviewed by Charles M. Iker, LCSW and their contracted supervisors and consultants for treatment and training purposes.

_____The recordings can be shown to other mental health professionals and trainees for training purposes.

_____The recordings can be used for research and/or scientific publications. No personal identifiable information would be disclosed in any publication.

_____The recordings can be shown to attendees at conferences/seminars/trainings/etc. where Charles M. Iker, LCSW is presenting.

To withdraw this permission to record, simply tell Charles M. Iker, LCSW, call (585) 461-4810 or email iker3860@gmail.com

By signing below, I acknowledge that I have read the above description and give my consent for the use of recordings as indicated above.

_____ _____

[Patient / Guardian] Signature Date

_____

[Patient / Guardian] Name (Printed)

If signed by Guardian, please indicate relationship to patient: _____

and name of patient (printed): _____