

CONSENT TO RELEASE THERAPY VIDEO RECORDINGS

I/We _____, clients of Dr. David Mark, MS, LCSW, EdD, hereby give consent to release the contents of any or all therapy videos via a secure (encrypted) internet webconferencing application (i.e., Skype videoconference) for the purpose of education, training and consultation activities. I/We understand that there is a chance, however slim, of a confidentiality breach **if** electronic security measures are breached (virus or malware) and have been informed that my therapist is using standard of practice security protections (passwords and virus protection).

I/We understand that health care information relevant to my therapy may also be released for the previous purposes, but that identifying information will be withheld or modified to maintain my confidentiality. I/We understand that the content of these recordings and relevant health care information will be released only to mental health professionals and trainees who are bound by law, professional college, or a confidentiality agreement to maintain client confidentiality.

I/We also understand that this consent only permits other professionals to review the recordings and health care information with my therapist, Dr. David Mark, MS, LCSW, EdD, and does not permit other parties to copy or retain possession of the previous information.

Finally, I/We understand the recordings will be erased at any time.

I/We understand that the recordings are property of David Mark, MS, LCSW, and may be erased at any time with no notice given to me and are not retained as part of the clinical record.

Client Signature

Client Signature

Witness Signature

Printed Name

Printed Name

Printed Name

