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Dr. Claudia Salazar
& associates

I, _____, authorize _____to audiotape and videotape my treatment sessions as an integral part of my therapy.

Consent is indicated by my signature below with the following restrictions.

1. The tapes may be used only in the following ways:
    a. For listening/viewing by myself and my therapist.
    b. For supervision and consultation with professional colleagues about my treatment.
    c. For transcripts and written reports to be used in research to improve the practice of psychotherapy.
    d. For training mental health professionals in the methods of psychotherapy.
2. Strict confidentiality will be preserved. In accordance with the ethical standards for licensed mental health professionals, identifying information about me will not be revealed.
3. There will be no financial compensation paid to me for use of these tapes.
4. The tapes may be edited.
5. At my written request, the tapes will be destroyed at the end of treatment.

Signature_____ Date_____

Printed Name_____