PERMISSION TO VIDEO TAPING THERAPY SESSIONS

I/We____

consent to the video taping of therapy sessions with Celedra Gildea, PhD, MFT.

I/We are aware of the presence of the video equipment and permit the use of all or part of the video tapes for the purpose of: (please initial below the type of use you are permitting)

_____ (initial) Our therapist and our review of our case to assist in our therapy.

_____ (initial) Our therapist's consultation with a clinical supervisor(s).

In no way will the refusal to grant consent for this video taping effect my/our getting assistance for myself/ourselves. If at any time during the treatment process, we wish to stop the taping we may do so and still continue treatment.

_____________________________ _____________________________
Signature/ Signature

_____________________________ _____________________________
Printed Name /Printed Name

_______________ _______________
Date /Date

Therapist's Signature: ____________________________________

Therapist's Printed Name: _________________________________

Date: _____________________________