Elizabeth Kennard
COUNSELING

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Consent to Release Therapy Video Recordings

I/We_____, client/s of Elizabeth Kennard, MSW, SWLC, hereby give consent to video record and share the contents of any or all therapy sessions with Jennifer Walrod, LCSW for the purpose of supervision under the Social Worker Licensure Candidate process. I/We understand 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 Elizabeth's SWLC supervisor, Jennifer Walrod, LCSW, who is also bound by law, professional college, or a confidentiality agreement to maintain client confidentiality.

I/We also understand that this consent only permits Jennifer Walrod, LCSW to review the recordings and health care information with my therapist Elizabeth Kennard, MSW, SWLC and does not permit other parties to copy or retain possession of the previous information.

Finally, I/We understand this consent is completely voluntary and that I/We are free to withdraw consent at any time while continuing to pursue the requested therapy services with Elizabeth Kennard, MSW, SWLC.

I/We also understand the recordings will be erased at any time.
I/We understand that the recordings are property of Elizabeth Kennard, PLLC and may be erased at any time with no notice given to me and are not retained as part of the clinical record.
I/We will be given a signed copy of this Consent Form.

_____

Client Signature Date

_____

Printed Name