Consent for Live Observation and Recorded Sessions

I authorize_______________________, a MA degree student associated with the Adler Graduate School, MN to videotape, audio tape and/or to observe a live clinical session in which I or the person(s) with whom I am legally responsible. The use of the digital media will be limited to educational purposes (e.g., case presentations and/or papers written to satisfy graduation requirements. My (client) confidentiality will be protected. All the necessary steps will be taken to make sure that my (client) identity will remain anonymous. The purpose of this authorization is to support the student's education and training. This authorization will be kept in my records and in the student’s records.

The Adler Graduate School will consider information to be "protected" or "disguised" within the meaning of these guidelines if there is no reasonable basis to believe that the information could be used to identify any individual and if the following steps are taken:

1. Last names are removed. First names are removed or changed.
2. Geographic references (such as references to the city, address and name of facility) are removed or changed. All dates directly related to the individual are changed or removed - including birth date, admission date, discharge date and age.
3. Any numbers that could be used to identify the individual are removed - such as social security numbers, telephone numbers, fax numbers, patient numbers, account numbers, medical records numbers, or any other unique identifying number or code.
4. Computer information such as e-mail addresses, URLs and Internet Protocol numbers are removed.
5. All other information, which could reasonably be used to identify the individual, is removed or changed.
6. Before the recordings or printed reports are de-identified, per all the items above, they will not be transmitted electronically or via other means.

This authorization may be rescinded by written notice at any time. I can request to stop recordings at any time, in writing or verbally without any explanation. I understand that the services that I am receiving will not be impacted by signing or not signing this authorization, or by rescinding it at any time.

This permission will expire on__/__/____ or sooner if rescinded. If I am signing this form for someone who cannot consent and if that person will gain consenting rights while this permission is in effect, the permission will be no longer valid and a new permission will be sought.

X _____________________________________________
I have received sufficient explanation concerning the purpose and the process of this authorization, student’s responsibilities, and names of the persons who will have access to the recordings.

I have received _____ I have declined _____ a copy of this form.

Signature: __________________________ Date: __________
Signature: __________________________ Date: __________
Name Printed: ________________________________________
Parent/guardian: ______________________________________
Date: _______________________________________________