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Authorization and Release to Record Psychotherapy

Name	First	MI	Last				
Address		Apt #		Phone	( ) -		
City		State		Zip		Birth Date	___ /___ /_____

I authorize Dr. Kuhn to make audio and/or video recordings of my treatment interviews. I understand that the use of these recordings will be restricted to the following purposes: (1) to be reviewed by Dr. Kuhn and me; (2) for consultation by Dr. Kuhn with colleagues to maintain and improve the quality of his treatment; (3) for research; (4) for training of mental health professionals.

This authorization shall remain in effect until Dr. Kuhn's retirement, or until revoked by me.

Conditions of Authorization	I understand that: • I do not need to sign this authorization, in which case no recording will take place. • I will not be denied treatment if I choose not to sign this authorization. • I am entitled to a signed copy of this authorization. • My full name will not be revealed. • The interviews, recordings, and any accompanying descriptive material will be used in accordance with the ethical standards of professional confidentiality for licensed mental health professionals. However, with the use of recorded material it is not possible to guarantee that I would not be identified. • These recordings will not become the property of anyone other than Dr. Kuhn or me. • I will not receive financial compensation for the use of these recordings. • I can revoke this authorization at any time, by written request to Dr. Kuhn, and that the recordings themselves will be destroyed on my written request. • The revocation is effective immediately on Dr. Kuhn's receipt of the written request, but the revocation will not affect any action taken by Dr. Kuhn prior to his receipt of the request.
Modifications	I have crossed out or modified any aspects of this authorization that I wish to change.
Signature	Signed: _____ Date: _____