I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_give permission to record (audio or visual) our session(s) provided by Working Choices, Inc.(WCI).

I give permission for the recording(s) to be used for the purpose of:

* Training or Certification and model fidelity adherence of therapist/home visitor
* Counting behaviors assessed and targeted by the PCIT practice

Monthly model fidelity/quality assurance; PCIT requires WCI to submit recordings to our PCIT trainer to ensure that the PCIT Contract providers are ensuring the fidelity of the PCIT Program. The recordings will not be edited, amended, or changed in any way from their original form. I the undersigned agree to random recordings during my PCIT sessions with my PCIT therapist.

The recording(s) will be kept (please check one):

Indefinitely \_\_\_\_\_\_\_ or until \_\_\_\_­­­­­­­­\_\_\_   (insert date)

The recording(s) will not be a part of your client record. All recordings will be kept confidential and with strict adherence to WAC laws and WA Code and Ethics concerning client confidentiality. The recording will only be viewed for the purpose of your intervention and the therapists compliance to the model. The PCIT trainer may view the video for these purposes as well and is likewise bound by the same laws regarding ethics and confidentiality.

All family members 13 years of age or older must sign the release authorizing WCI to record the session(s). A parent or legal guardian must sign the release for all family members under 13 years of age. This release allows WCI to record the following individuals:

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of family member(s)** | **Date of Birth** | **Age** | **Name of parent/legal guardian (for family members under 13)** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

I authorize WCI to record the above listed family members and WCI therapist/home visitor during our session(s). I understand the recording(s) will be used for the purpose explained above. I, the parent/legal guardian listed above, have full authority to authorize the use of recordings of the minor children named above.

I will not hold Working Choices, Inc. or WCI therapist/home visitor liable in any way for using the recordings I have authorized. I sign this authorization and release voluntarily, and under no duress from WCI, or any other person or organization.

I understand that I may withdraw my consent any time by submitting a written request to WCI.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Print Name                                               Signature                                       Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name                                                Signature                                       Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name                                                Signature                                       Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Debra S. Hatton, LMHC, PCIT Therapist     Signature                                       Date