adapt
Integrated Health Care

CONSENT TO AUDIO VIDEO RECORDING

For services provided by Adapt Integrated Health Care, hereafter referred to as "Adapt"

I hereby grant the Adapt authorization to audio or video record my group, individual, or educational counseling sessions for the purpose of improving the quality of treatment provided by Adapt staff.

I understand that these recordings may be viewed or heard by my counselor's supervisor and appropriate clinical staff at Adapt for training and supervision purposes only. The recordings are considered confidential and will be subject to all federal confidentiality regulations as outlined in 42 CFR. Part 2. The recording will be deleted after use in training and no permanent record of the session will be kept.

I understand that I may revoke this consent and release in writing at any time except to the extent that action has been taken in reliance on it.

Unless revoked sooner, this consent and release expires (choose one):

☐ One year from date of signature

☐ Specific date event or condition

Revocation condition: _____

I understand that my participation is entirely voluntary. I also understand that my treatment, payment, enrollment, or eligibility for benefits is not contingent on whether or not I sign this consent and release. It has also been explained to me that if I refuse to consent the only consequence of refusal will be that no audio or video recordings will be made. I will not receive any compensation for my agreeing to audio or video recording of my counseling sessions.

I consent: ☐ Yes ☐ No

Comments: _____

I **have read and agree to the statements above.**

_____	_____	_____
Patient Signature	**Parent/Legal Guardian Signature**	**Date**

Print Name / Relationship to Patient:

_____

* In the event a legal representative other than a parent of minor child signs this Authorization, a documentation of legal authority must be attached (e.g., Health Care Power of Attorney or Notarized Health Care Representative form).