AGREEMENT TO RECORD THERAPY SESSIONS FOR CONSULTATION/TRAINING

In order to constantly improve my counseling I like to record my therapy sessions. If you are comfortable with this I need your written permission. Our work in counseling will not be affected by the recording and you are free to say no. If at any time you change your mind we can stop the recording.

We give permission for ____________________ to record our counseling sessions for the purpose of getting further training from Lorrie Brubacher, M.Ed. LMFT (NC # 1245), Certified Trainer and Supervisor in Emotionally Focused Therapy (EFT).

Please initial the options agreeable to you. (Initials)

1) For our therapist __________________________ to review outside of sessions.

____ ____

2) For our therapist __________________________to use in meeting with cosultant/trainer L. Brubacher to help me learn the EFT model.

____ ____

3) For our therapist __________________________ to use in consultation/training groups of other therapists.

____ ____

We understand that the recordings of the session(s) and the consultant's feedback to the therapist will be kept private and confidential by the consultant/trainer L Brubacher. We understand that no names or identifying information other than what is on the recording will be provided to anyone.

We also agree that the consultant is only responsible for providing training/consultation to the therapist on the use of the EFT model.. This training is a service to the therapist. The therapist is then solely responsible for the conduct of our therapy sessions and any outcomes of these sessions. In consideration of the consultant providing the training to the therapist in the EFT model, we agree that the consultant Lorrie Brubacher shall not be, in any way, held responsible by us or by any other person associated with us for what occurs in any of our therapy sessions or the outcome of those sessions.

In the case where we agree that a recording of our session can be used by our therapist in small group consultation with other therapists and the consultant/trainer Lorrie Brubacher, (# 3 above) we understand that our confidentiality will be protected at all times. If any therapist in the

consultation group knows either of us in any way whatsoever he or she will not view the recording and will keep confidentiality as per standard professional guidelines.

Signed:

Name: ____
(Signature)

____
(Print)

Name: ____
(Signature)

____
(Print)

Therapist: ____
(Signature)

____
(Print)

Date: __________________________________