Laura G. Doherty, LCSW

CONSENT FOR AUDIOVISUAL RECORDING

I, _____, hereby give my consent to the audiovisual recording of my psychotherapy sessions with Laura G. Doherty, LCSW.
I understand that these recordings will be used to further my treatment, and may also be used for research and training purposes. They may be shown to a colleague in a supervisory or consultation capacity. I understand that transcripts will be used for these purposes and in accordance with the highest standards of confidentiality and professional ethics.

I release L. Gay Doherty, LCSW from any liability or claim in connection with the use of these video recordings for the above stated purposes. I understand that I shall receive no financial compensation for the use of these audiovisual recordings.

Date: _____

Printed name _____

Signature _____

Home address: _____

_____

Date of Birth: _____