Desert Vista Counseling Services, L.L.C.

Mesa Location
2929 N. Power Rd. Suite 101
Mesa, Arizona 85215
Ph: 602-550-9393
Fax: 623-565-8016

www.desertvistacounseling.com

Scottsdale Location
7403 E. 6th Ave., Suite 5
Scottsdale, AZ 85251
Ph: 480-946-3082
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AUTHORIZATION TO UTILIZE VIDEO OF SESSIONS FOR SUPERVISION PURPOSES

Name: ______________________________, ___________________________ _______________
Last First Middle Initial

Date of Birth: ______ / ______ / ______
month day year

Address: ______________________________________ _____________________ _____ ______
street city state zip

Home Phone: __________________________ **Work Phone:**___________________________

Cell Phone:____________________________

I hereby give consent to my therapist, _________________ ______________ _____________**, to utilize**
Therapist's first name *last name* *credentials*
the content of my therapy sessions for the purpose of supervision. I authorize her to do the following(check all that apply):

____ video record sessions

____ broadcast therapy sessions live to supervisor via Skype, or similar video conferencing internet programs, for participation in live supervision

____ email recorded sessions to supervisor(s)

____ review and discuss my case and any video of my therapy sessions with supervisor

This consent will expire one year from the signed date below. I have given my consent freely, voluntarily, and without coercion. I may revoke this authorization anytime, providing that I notify the Dr. Gold in writing of my intent to revoke. I understand that any release made prior to my revocation, in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. I understand that a photocopy or facsimile of this authorization is considered acceptable in lieu of the original.

_________________________________ ______________________________ ___________
Printed Name of Client/ Legal Guardian **Signature of Client/Legal Guardian** **Date**

_________________________________ ____________________________ ____________
Printed Name of Therapist **Signature of Therapist** **Date**