Authorization to Release Audio/Video Recordings

Client Name: _____ Client DOB: _____

By signing this authorization, I hereby give permission to Families First of Florida to Release and review:

☐ Audio ☐ Video of my therapy session(s).

Permission is granted to release audio/video to the following:

University:_____

Student Instructor: _____

Address: _____

Please specify information to be released/requested.

☐ Audio of my Therapy Sessions(s) ☐ Video of my Therapy Session(s)

- This information will be used for providing supervision to my therapist and/or evaluating my therapist training by their university instructor.
- I understand that I have the right to refuse to sign this authorization and that my refusal to sign will not impact my right to treatment. I understand that any disclosure is bound by Title 42 of the Code of Federal Regulations.
- By signing this authorization, I am agreeing to release audio and or video of my therapy session(s) containing mental health, and if applicable, substance abuse, gender affirming, reproductive health care and HIV information.

Although the recipient is not permitted to release the information without additional written consent Families First of Florida cannot be held responsible for further use or re-disclosure by the recipient.

This authorization is valid for (1) year after the date of my signature or will expire on this date_____/_____/_____.

This authorization can be revoked at any time upon written notice, revocation does not affect release/request prior to the notice.

Signature of Client_____ Date _____

Signature of Legal Guardian_____ Date _____

Printed name of Legal Guardian _____ Relationship to Client _____

Telephone Number *(813) 290-8560* ***Choose*** *Records (Option 5)*
Fax Number *813-354-2416* ***Email Address*** *records@familiesfirstfl.com*
www.familiesfirstfl.com