DAVIS BEHAVIORAL HEALTH
Community • Commitment • Change
801.773.7060 www.dbhutah.org

Authorization to Audio/Video Record Treatment Sessions

(Please note: Clients of substance abuse services must also complete the Authorization to Use and Disclose Health Information)

By signing below, I hereby authorize Davis Behavioral Health, Inc. (DBH) to audio/video record my (or my child's) treatment sessions. I understand and agree that the purpose of any audio/video recording will be one of the following: 1) to improve clinical outcomes at DBH through training and enhancing clinicians' skills, or 2) to provide Parent-Child Interaction Therapy (PCIT). I understand and agree that any audio/video recording is the property of DBH and is not part of my (or my child's) medical record. Any audio/video recording will be kept in compliance with applicable federal and state laws, rules, and regulations and will be deleted after 180 days

I understand that I have no obligation to authorize audio/video recording of my (or my child's) treatment sessions. My (or my child's) treatment will not be adversely affected if I decline to authorize the audio/video recording of treatment sessions.

I hereby authorize Davis Behavioral Health to audio/video record any and all of my (or my child's) treatment sessions. This authorization will remain in force unless revoked by myself or a legal guardian.*

_____
Client name (print)

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Signature Date

_____
***I hereby revoke my authorization** for the audio/videotaping of treatment sessions at Davis Behavioral Health, including the further use of all past sessions in which I (or my child) participated that were audio/video recorded.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date