THE Theraplay® INSTITUTE
Building Better Relationships

Consent to Videotape

Date _____

I give _____ permission to video me and my child in all assessment and Theraplay sessions while my family is receiving therapy. Video will be used by the therapist in his/her treatment of my family (for example, we review portions of sessions with you to enhance positive treatment outcomes) and for supervision with a qualified Theraplay supervisor. Supervision may take place in a one-on-one or group format in person or online, or in a group format. I understand that these videos and the content of these sessions are confidential. I understand that I may withdraw my permission to video with a written request. The consequence for not giving this permission is that the therapist and your family will not be able to review the sessions and therefore may impede optimal treatment your family.

Signature _____

Name _____

Child's Name _____

Address _____

City, State, Zip _____

Home and cell # _____

Witness _____

Additional Permission:

The Theraplay Institute is a training facility for mental health professionals interested in receiving education, training, and certification in Theraplay. My signature below gives The Theraplay Institute permission to use the videos of myself and my child in Theraplay treatment for future Theraplay trainings of other mental health professionals. I understand that I may withdraw my permission to video with a written request. There are no negative consequences for not giving consent to this permission.

Signature _____