

**Carrie Sheppard, M.Ed..**

Licensed Mental Health Counselor

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**AUTHORIZATION TO VIDEOTAPE**

I, \_\_\_\_\_

HEREBY AUTHORIZE VIDEOTAPING OF:

yes  no myself  
 yes  no my child (name) \_\_\_\_\_

This/these videotape(s) may be viewed by the following parties:

yes  no **Carrie Sheppard M.Ed., LMHC**  
 yes  no Professional associates of Carrie Sheppard for clinical consultation  
 yes  no Connections Center, for training or supervision purposes  
 yes  no Parents, on an individual basis, for educational purposes only  
 yes  no Professionals, individually or in groups, for educational purposes  
 yes  no Parents in groups, for educational purposes  
 yes  no Other \_\_\_\_\_

I understand that videotapes cannot be released without my specific consent. I understand that this consent can be revoked at any time, and that I may request that any or all videotapes be returned to me.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(if client is a minor)

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Carrie Sheppard, M.Ed., LMHC

*This authorization applies to any health information gathered within 90 days from the date of this signature.*