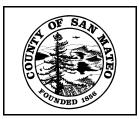
CONFIDENTIAL
PATIENT
INFORMATION:
See California
Welfare and
Institutions Code
Section 5328

San Mateo County Health System Behavioral Health & Recovery Services

AUTHORIZATION for SESSION RECORDING and/or 1-WAY MIRROR OBSERVATION



Clien	ent NameMH Number	
l do h	hereby give my consent to have counseling sessions observed and/or	recorded.
I understand that this taping will be treated with complete confidentiality and will be discussed only with the clinical staff within this agency and, in the case of clinical trainees, with the immediate clinical supervisor of the trainee. If the taping is discussed in an educational setting no clients or families will ever be identified by name.		
	s authorization shall be valid untilumstances, the consent must be renewed annually.	In all
I cons	nsent to the following conditions:	
1.	1. Audio Recording	
2.	2. Audio/Video Recording	
3.	3. One-Way Mirror Observation	
4.	4. Other (specify)	
I unde	derstand that my consent is voluntary and may be withdrawn at any tim	e.
Signa	nature Date	
	nature Date Client/Legal Representative	
If sign	gned by someone other than the client, state legal relationship to the cli	ent:
Origin	ginal to Client Chart	
cc:	Client	
	Authorized Clinician	