**Instructions on obtaining consent to audio/video record sessions:** You are free to use the form below to obtain consent from clients to record sessions or you can use your own internal release form. Regardless of which form you choose to use, please do NOT send the authorization for release of protected health information (PHI) to me, but instead, keep it in the patient's medical chart.

**Example script**

Below we provide a script you can use when you ask the client for their permission to record:

As part of my professional development, I regularly participate in trainings to improve my therapy skills. I am currently receiving some training in a therapy method, called Acceptance and Commitment Therapy, that I think may particularly fit your situation. One way for me to improve what I do is to record my sessions and have a consultant listen to them. I am wondering whether you would be willing to have some of our sessions recorded so that I can get feedback on my therapy practice. If you are willing to have some of our sessions recorded, I want you to know that your personal information will be strictly confidential, and that your name will not be released to the consultants or connected to the recording in any way. The recordings will be destroyed immediately after they are reviewed by the consultants and feedback is provided to me. If you are willing to have me record your sessions, I’ll have you fill out an informed consent form that we will keep in your chart. Whether or not you agree to this will have no impact on our work, or our relationship. If at any point you want us to stop recording or feel like this is interfering with your therapy, you can always let me know and we will stop it.

**Instructions on uploading the recording and maintaining security/privacy**

Once you have made a recording, you can upload it to the following location:

<https://www.filesanywhere.com/Dropbox/db.aspx?v=89716a8c5b60a37ba69a>

Please label the file with **your initials and the date of the session**. DO NOT link the client's name to the recording in any way. The website will alert me when the file has been uploaded, so you do not need to send me an email to let me know it’s up there. The maximum upload size for a file is about 2GB. This is very large for an audio file, but video files may need to be compressed. Large files can take minutes or hours to upload.

This upload link uses high security transfer protocol and the server to which it is uploaded is encrypted. My computer is also encrypted and I take every measure to keep the file secure, including deleting it as soon as I am done using it for consultation purposes.

Once you have uploaded the audio file, please take care to thoroughly delete it. I recommend using a program like Eraser (<http://eraser.heidi.ie/download.php>) to thoroughly erase the file from your hard drive. If you do not use Eraser, then make sure you empty your recycle bin on your computer after you delete the file. Otherwise, the file will remain on your hard drive.

It often is helpful for me if you also send me a little bit of information about the session that you uploaded. For example, you might consider sharing any reflections on the session about what you were working on in the session, what you thought went well, what didn’t go so well, and any places you would like some input. You can either enter that on the upload page or send it to me in a separate email.**Authorization Form For the Use and Disclosure of Patient Health Information**

Patient Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your therapist is currently obtaining consultation in an evidence-based therapy called Acceptance and Commitment Therapy (ACT). You are being asked to allow your therapy sessions to be recorded so that your therapist can get feedback on his/her use of that method.

You do not have to authorize your therapist to record your sessions. If you decide not to allow your therapist to record your sessions, it will not affect your ongoing therapy in any way. If you decide to allow your therapist to record your sessions, the recordings will be uploaded to a secure website and be reviewed by the consultants who will provide feedback to your therapist on his/her use of the technique. These recordings will be destroyed within 24 hours of when feedback is provided to your therapist.

Your therapist and the consultants have taken several precautions to ensure the confidentiality and security of your recordings, including use of very secure online systems, keeping the recordings confidential and anonymous, and destroying the recordings as soon as possible. The file will be identified only by your therapist’s name and the date of the session. Your name will not be connected to your audio recording in any way. This form, if you sign it, will be kept in your medical record and your name will not be released to the consultants.

**Signed Statement**

By signing this Authorization Form, I understand that I am giving permission to my therapist and his/her designated medical record custodians to use and/or disclose my Protected Health Information, as described below, to the following person(s) or organization(s):

* Jason Luoma Ph.D, Portland Psychotherapy Clinic, Research, & Training Center, 3700 N Williams Ave., Portland, OR 97212, (503) 281-4852, email: jbluoma@portlandpsychotherapyclinic.com

I specifically authorize the use and/or disclosure of the following Protected Health Information:

* A*udio and/or video recordings of therapy sessions*

This Protected Health Information is being used or disclosed for the following purposes:

* *For my therapist to obtain consultation on his/her use of new therapy techniques*

I understand that I may revoke this authorization at any time by notifying my therapist of my intent to revoke the authorization. I understand that such a revocation will not have any effect on any information already used or disclosed before my written notice of revocation is received. Unless you decide to stop participating earlier, this consent expires 30 days after the last recording is made.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I may inspect and receive a copy of the information to be used and disclosed pursuant to this authorization form. I understand that I may refuse to sign this authorization form and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

Printed Name

Signature Date