CONFIDENTIAL PATIENT INFORMATION
See: Cal. W & I Code Sec. 5328 and
45 CFR, Part 164

Client Identification

County Of Orange
Health Care Agency
Behavioral Health Service

CONSENT TO RECORD

I, _____, give my permission for the
Name of client/person to be recorded

☐ audio only
☐ audio and video

recording of my therapy sessions. I understand that any and all such recordings will be used only for the purposes of clinical supervision and teaching, and that any such recordings will be destroyed following the completion of such clinical supervision or teaching. I further understand that these recordings will not be reproduced in any form, that the information thereon is subject to all applicable Federal and State regulations governing confidentiality of client records and treatment, and that the recordings will be used only by authorized employees, volunteers and/or students working in the County of Orange Health Care Agency/Mental Health and Drug Abuse Services.

I understand that I may revoke this consent at any time, and that my receiving treatment is not contingent upon my signing this consent nor agreeing to any recording. I also understand that this consent expires at the time of my discharge, unless revoked earlier by me.

_____ _____
Signature of Client Date

_____ _____
Signature of Witness Date

_____ _____
Signature of Service Chief Date

Original to: Clinical Record Copy to: Service Chief, Client