

## CONSENT FOR VIDEOTAPING

I/we authorize the Dual Diagnosis Treatment & Training Services (DDT&TS) to videotape my son/daughter/ward/self \_\_\_\_\_ as deemed necessary to evaluate behavior(s). This tape will be used for evaluation and training (e.g., in-servicing staff, presentations, etc.) purposes only. I understand that I have the right to withdraw this consent at any time and that I have the right to view any videotape made of my son/daughter/ward. I understand that the videotapes may be kept for future reference by the DDT&TS team following the consultation, but will not be released to anyone without my express written consent to release any videotape(s).

This consent will expire on \_\_\_\_\_. If left blank, this consent will expire 30 days after the case is closed.

\_\_\_\_\_  
Client/Consumer Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

**NOTE: Consent will not be considered valid without a witness' signature and the client or parent/guardian signature.**