

**Permission to Video Recording and Case Discussion  
("Recording" can include CDs, Videotapes and DVDs)**

I, \_\_\_\_\_, give my permission for the recording and/or discussion of  
my EMDR session(s), and for the presentation of my clinical progress, \_\_\_\_\_.  
Client Name Therapist Name

The purpose of the review is for the listed therapist's professional development in EMDR practice.

- I understand that confidentiality is of utmost importance and that my name will not be used in the presentation nor will identifying information be shared.
- I understand this presentation of my session(s) will be reviewed by the named therapist with the involvement of an Approved Consultant in EMDR, and potentially other Consultants in Training and /or Certification Applicants.
- I understand that any recording will remain in the control of the named therapist and/or Approved Consultant at all times, and will not be reproduced, unless by separate consent.
- I understand that any recordings will be destroyed immediately when the review process is complete.
- I understand this release will be retained in my file, unless I rescind it.
- I understand that I can rescind this consent whenever I choose and that any recording of my session(s) will be discarded at my discretion and direction, after discussion with the named therapist.
- I understand that if I am involved, or likely to be involved, in litigation, that I may choose to decline this request for any recording or use of my clinical material, as caution against possible subpoena.
- I understand that there is no obligation to consent, with no penalty or consequence for declining, and I consent freely.

I do not want my face filmed: \_\_\_\_\_ (initial here)

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Therapist

\_\_\_\_\_  
Date