INFORMED CONSENT TO VIDEO RECORD

I, _____, give my consent to videotape my Somatic Experiencing® (SE) sessions. My signature below confirms that conditions of my consent to be videotaped have been explained to me and I understand the following:

- I am not required to be videotaped and I am under no obligation to have these sessions recorded.
- I can withdraw my permission at any time during or after each session.
- My access to SE sessions will not be affected by my decision not to be videotaped.
- I have the right to review recordings with my practitioner during one of my sessions.
- This tape will be viewed by a Senior Faculty Member from SE Trauma Institute during a consultation meeting with my SE Practitioner to increase the effectiveness of SE sessions.
- Only my first name will be used or my name will not be mentioned.
- The contents of each video will remain confidential within the consultation unless I give my express written consent otherwise.
- I may revoke this videotaping consent at any time.
- I may contact my SE Practitioner at any time with questions or concerns at _928-266-6871_ .

_____ _____

Signature of Client Date

_____ _____

Signature of Parent/Guardian if Client is under 18 Date

_____ _____

Signature of Somatic Experiencing® Practitioner Date