St. Clair County Community Mental Health Authority

Audio-Visual Authorization Consent

Case #_____

I, _____ authorize, and consent is hereby given for
(Individual/Parent/Guardian Name)

- ☐ Photographing
- ☐ Audiotaping
- ☐ Videotaping
- ☐ One-Way Mirror
- ☐ Observation
- ☐ Fingerprinting

of _____ at the _____ for purposes of
(Individual's Legal Name) (Location)

_____

_____

_____

(i.e., treatment, education, information, therapist training)

I understand that the material(s) will be erased/destroyed following their stated purpose(s). This consent is effective only for the period beginning _____ and ending _____.
(Date) (Date)

I understanding that these materials will be treated as confidential information and will not be released/used by anyone other than St. Clair County Community Mental Health direct and contract personnel. I further understand that I will remain anonymous. Lastly, I understand that the material(s) will be erased/destroyed within effective dates of this consent.

I can withdraw my consent in writing at any time during this period.

I further understand that my signature does not waive my legal rights, including release of the program, or its agents, for liability for negligence.

_____ _____

Individual Legal Signature Date Individual Legal Signature Date

_____

Parent/Guardian Legal Signature Date

_____

Witness/Staff Member Legal Signature Date

Distribution:
1. Original filed in Individual's File.
2. Copy to Individual.

Clinical Form: #03-0016
Reviewed Date: 9/1/2023
Policy Ref: #03-002-0025
EHR: Legal/Consents, Consent for Treatment Note: Audio-Visual Authorizations/Consent