***Current Form as of June 24, 2021***



**Wellness Center**

**Consent to Recording In-Person Counseling Sessions**

#### Loyola University of Chicago (“LUC”) Wellness Center (“LUC WC”) serves as, among other things, a training clinic for mental health professionals and professionals-in-training completing degrees at LUC. In-person counseling sessions may be recorded for purposes of supervision and training and professional development of the counselor and to ensure that the counselor is delivering the most effective care possible (collectively, the “Training Purposes”). Recordings are protected and confidential and are ultimately erased. You are not required to have your in-person counseling sessions recorded if you do not wish them to be. LUC WC will not make video, audio or photo recordings of telehealth counseling sessions conducted via telephone or videoconference (rather than in-person), whether via a smart phone with videoconferencing capability or by tablet or computer, using an authorized, non-public facing video conferencing technology; provided, however, that the operator of the telephone or videoconference platform used for such services may be able to hear, observe or have a backup copy of telephone or videoconference communications.

#### I authorize LUC and its employees and agents (including LUC WC and its employees and agents) to make a recording of me, my image and voice during my in-person counseling sessions on video, film, photograph and any other medium and to use my name, likeness and voice in connection with the recording and to use the recording for the Training Purposes.  I waive the right to inspect or approve the recording, and I agree that the recording remains the property of LUC. I release LUC and the parties above from any and all claims, liabilities, and costs in connection with the recording and its use. This consent is valid throughout the course of my treatment and may be revoked at any time without consequence to me and without jeopardizing my care at the LUC WC in any way.

#### **Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

#### **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

#### **Parent/Guardian Signature (if under 18 years of age): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

#### **Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**