CONSENT FOR AUDIO/VIDEO RECORDING FOR THE PURPOSE OF SUPERVISION

DEPARTMENT OF HEALTH AND HUMAN SERVICES
FIELD SERVICES
SFN 1151 (3-2025)

Clear Fields

Client Name	Client ID	Date of Birth
Episode	Admission Date	Current Date

I consent to participate in an audio/video recording for the purpose of supervision.
☐ Yes ☐ No

I understand that these recorded materials will not become part of my clinical record. These materials will be stored in a secured area until their purpose has been served, at which time they will be destroyed, no longer than six months from date of recording. I understand that:

- I am not required to be audio/video recorded and I am under no obligation to sign this consent form;
- My access to services will not be affected by my decision not to be audio/video recorded;
- I may revoke this consent at any time by submitting a written request to withdraw my permission.

I understand the conditions, and have had an opportunity to have any questions answered.

Signature of Client or Legal Representative	Date