

**CONSENT TO THE USE OF PHOTOGRAPHY AND/OR  
AUDIO/VIDEO TAPE RECORDING**

Client Name \_\_\_\_\_ Client ID # \_\_\_\_\_

I, \_\_\_\_\_

Voluntarily authorize Mid-Ohio Psychological Services, Inc Other \_\_\_\_\_

(Check all that apply): To take my (or my child's) photograph;  
To make an audio-tape recording of my (or my child's) voice;  
To make a video-tape recording of me (or my child);

The purpose for the photographing, audio/video recording is:

(Check all that apply): As an essential means of identifying me (or my child)  
For exclusive use in therapy  
For use in evaluation and assessment of psychological testing  
For use in MOPS approved research  
For use by MOPS staff/interns training and development  
For use by the following public news media: \_\_\_\_\_  
For community training (specify date of destruction): \_\_\_\_\_  
Other (specify): \_\_\_\_\_

Except for photographs or tapes taken by public news media or community training, any photograph or audio/video recording will be treated as confidential and will be secured in my (or my child's) clinical record. I also understand that this consent is only valid for ninety (90) days from the date of my signing unless otherwise specified for community training. The photograph, digital image, or audio/video recording will be given to me or destroyed when no longer necessary for the purpose it was authorized.

**CONSENT**

I have read and understand the information in this agreement or it has been clearly explained to me in a way I can understand. I voluntarily agree to this agreement with the understanding that I am free to withdraw my consent at any time without prejudice by signing the withdrawal of consent portion of this form below or by notifying Mid-Ohio Psychological Services, Inc by registered letter to the Executive Director.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Client)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Guardian or Parent of a Minor)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(MOPS Staff or Witness)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(MOPS Staff Supervisor)

**WITHDRAW OF CONSENT**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Client)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Guardian or Parent of a Minor)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(MOPS Staff or Witness)