Diane Byster, LMFT, NCC, RYT
Licensed Marriage and Family Therapist, Career Consultant, and Registered Yoga Teacher

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CONSENT TO VIDEOTAPE

Please initial to the right of each numbered item,
then sign and date at the bottom.

I, _____, authorize Diane Byster, LMFT to videotape my psychotherapy sessions with her as an integral part of my consultation and treatment. I understand that Diane Byster is committed to studying the process of treatment in order to make psychotherapy more effective and efficient. I understand that the use of my videotapes is limited and may occur only in accordance with the highest ethical standards of professional confidentiality for California mental-health practitioners.

Viewing of my videotapes is strictly limited to the following: *Initial*

(1) Review by Diane Byster to optimize the quality of my care; _____

(2) Use by Diane Byster for the purpose of receiving professional consultation about my treatment; and _____

(3) Use by Diane Byster for the purpose of teaching and training of other mental-health professionals. _____

I understand that my name will never be disclosed, and that the tapes will be used solely for the purposes described above. I further understand that the tapes are not part of my permanent medical record.

_____ _____
Signature Date