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

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CONSENT TO VIDEOTAPE

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:

(1) Review by Diane Byster to optimize the quality of my care _____ (client initials)
(2) Use by Diane Byster for the purpose of receiving professional consultation about my treatment _____(client initials)
(3) Use by Diane Byster for the purpose of teaching and training of other mental-health professionals _____ (client initials)

I understand that if I am not comfortable with (3) above, I can cross out that line and initial it to indicate my wish to exclude that specific use of the videotapes.

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 and that Diane Byster will destroy each recording after it has been used for its intended purpose.

_____ _____
Client's Signature Print Name Here

_____ _____
Client's Signature Print Name Here

_____
Date Signed

_____ Diane Byster
Therapist's Signature