**CONSENT FORM FOR AUDIO RECORDING**

I, , the undersigned, hereby agree to have my therapy session audio recorded for the purpose of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (insert therapist’s name) application for certification status in cognitive-behavioural therapy by the Canadian Association of Cognitive and Behavioural Therapists/Association canadienne des thérapies cognitives et comportementales (CACBT-ACTCC).

I understand that at no time will my name or other identifiers be revealed and that the audio recording will be used only for the purpose listed above.

I understand that the audio recording of this session will be sent by secure means of transmission for this purpose. I understand that the recording will be managed and used according to the privacy policy of CACBT-ACTCC which can be found on our website (www.cacbt.ca). CACBT-ACTCC will keep this recording until the process to determine certification status is complete.

I understand the meaning and the implications of this document which have been explained to me by and give, of my own free will, my consent to the conditions listed above.

Client signature Date

***If client is a minor, please sign consent above, but have parent or legal guardian sign below:***

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the parent or legal guardian of, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand that the audio recording of this session will be sent by secure means of transmission for this purpose. I understand that the recording will be managed and used according to the privacy policy of CACBT-ACTCC. CACBT-ACTCC will keep this recording until the process to determine certification status is complete.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or legal guardian signature Date