Carrie Sheppard, M.Ed.
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AUTHORIZATION TO VIDEOTAPE

I, ____

HEREBY AUTHORIZE VIDEOTAPING OF:

☐ yes ☐ no myself
☐ yes ☐ no my child (name) ____________________________________

This/these videotape(s) may be viewed by the following parties:
☒ yes ☐ no **Carrie Sheppard M.Ed., LMHC**
☐ yes ☐ no Autism Family Support Team Associates for consultation purposes
☐ yes ☐ no Professional associates of Carrie Sheppard for clinical consultation
☐ yes ☐ no Connections Center, for training or supervision purposes
☐ yes ☐ no Parents, on an individual basis, for educational purposes only
☐ yes ☐ no Professionals, individually or in groups, for educational purposes
☐ yes ☐ no Parents in groups, for educational purposes
☐ yes ☐ no Other ____

I understand that videotapes cannot be released without my specific consent. I understand that this consent can be revoked at any time, and that I may request that any or all videotapes be returned to me.

Client Signature: ________________________________ Date: _____/_____/_____

Parent Signature: ________________________________ Date: _____/_____/_____
(if client is a minor)

Witness Signature: ________________________________ Date: _____/_____/_____
Carrie Sheppard, M.Ed., LMHC