Truth in Love Counseling

Keith Nelson, M.Div., M.A.

CONSENT TO RECORD THERAPY SESSION

I hereby give permission to Keith Nelson to record our therapy session(s) on audio. I understand that the purpose of this recording is to enable Keith Nelson to review and evaluate our therapeutic work together, so he can improve the level of care.

My signature below indicates that I give permission for Keith Nelson to record our session(s), and I understand the following:

1. I can request that the audio recorder be turned off at any time.
2. I may also request that the recording, or any portion of it, be erased.
3. I can revoke my permission for recording at any time.
4. The contents of the recorded sessions are confidential, and the information will not be shared outside of our sessions.
5. The recordings will be stored securely and will not be used for any other purpose without my written permission.
6. The recordings will be erased after they have served their professional purpose. The transcripts will be stored in your file.

Please know that if you do not wish to do this, you are free to say no. Our work in your counseling will not be negatively affected if you decide not to. Once the recordings are reviewed, they are deleted. If a transcript is produced, this will be kept on your file.

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Client Signature   Date

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Client Printed Name