Session Audio Recording Consent Form

Child's Name: (please print) _____

Parent/Guardian Name: (please print) _____

I, _____ give permission for the treating therapist to record and collect audio from my child's session.

I understand that the purpose of recording these sessions is for treatment and assessment purposes, and that the recordings will be analyzed and stored by Ambiki's HIPAA Compliant Tenalog for progress tracking. The therapist may use this data to determine appropriate treatment steps and planning, and to share progress towards goals with parents and legal guardians as requested.

I understand that the recording will be kept confidential and will only be accessed by the therapist and authorized healthcare professionals involved in my child's care.

I understand that my child's participation in therapy sessions is voluntary and that I may withdraw my consent at any time by notifying the therapist in writing.

I also understand that my child's therapy sessions will not be affected if I choose not to provide consent for the use of Tenalog or if I choose to withdraw my consent at a later time.

I have read and understand the above information, and I give my consent for the audio recording of therapy sessions with Tenalog.

Signature: _____ Date: _____