DR. LUCILLE KEENAN
Clinical Psychologist
1330 St. Mary's Street • Suite A020 • Raleigh • NC 27605
919 • 604 • 7401

Informed Consent to Videotape and Release Information

By signing below, I give my consent to allow my counseling sessions with Dr. Lucille Keenan to be electronically recorded. I further consent that she may share this recording with other therapists in her consultation group. I understand that any other therapist who watches this recording for training purposes is under the same confidentiality requirements as my therapist. Further, I understand that if by chance any therapist knows me socially or personally, he/she will immediately leave the session and will not observe, seek or be given any information about my situation.

I understand that I may request the electronic recording to be discontinued at any time either temporarily or permanently.

I understand that Dr. Lucille Keenan may retain, but is in no way required to retain any electronic recordings produced in this process. I authorize Dr. Lucille Keenan at her sole option, to erase or otherwise destroy any and all recordings after they have been used for the intended purpose, or at any other time, whether they have been used or not. I understand that these recordings are not part of my treatment record.

I understand that my decision about whether or not to permit electronic recording will have no impact on the treatment I will receive. I understand that I may withdraw this consent at any time.

NAME: _____Date: _____

SIGNATURE: _____

NAME: _____Date: _____

SIGNATURE: _____

Dr. Lucille Keenan: _____Date: _____