Elisa Horton, LMFT, LMHC, NCC, Inc
DBA Better Together Counseling
Elisa Horton, LMFT, LMHC, NCC
FL Lic # MT 2182 and MH 8749
(772) 426-9955; (772) 781-1818

AGREEMENT TO RECORD THERAPY SESSIONS FOR CONSULTATION/TRAINING

Date: _____

We (members of the couple's printed names), _____, give permission for Elisa Horton, LMFT, LMHC, NCC (Elisa) to record our counseling sessions. The purpose of Elisa recording sessions is to improve our quality of care, Elisa's understanding and embodiment of the EFT/EFFT/EFIT model(s), and/or her certification in the model(s). Viewers of our recorded sessions may include Elisa herself, Elisa's Clinical Emotionally Focused Peer Supervision Group and/or Clinical Emotionally Focused Supervisor, and/or a representative of the International Centre for Excellence in Emotionally Focused Therapy (ICEEFT)). Recordings will be disposed of/ destroyed by Elisa or a representative of ICEEFT in a manner consistent with applicable laws and rules immediately once they have been reviewed and our recorded material held confidential.

We understand that the recordings of the session(s) and the consultant's feedback to Elisa will be kept private and confidential. We understand that no names or identifying information other than what is on the recording will be provided to anyone. If shared in a consultation group - any therapist that knows either of us in any way whatsoever will not view the recording/will step out unless otherwise granted written consent/permission by us (in the case of the other therapist being a current or past therapist of either of us) and that any present therapist will keep confidentiality as per standard professional guidelines and laws.

We consent to have the recording of our session(s) be viewed by a representative of the International Centre for Excellence in Emotionally Focused Therapy (ICEEFT). We understand that this recording will be kept confidential and viewed only by a Certified EFT therapist/supervisor as part of the ICEEFT Certification procedure. The ICEEFT representative will also take responsibility for destroying the recordings after viewing them.

We understand that we can request to stop recording at any time. We understand that we can decline this authorization to record and are signing this of our free will as we understand it will be helpful to our treatment. We understand if we do not sign it that we will not be penalized in any way.

Signed:
Client (s) Name: _____
Client Signature: _____
Client Signature: _____
Therapist name: _____
Therapist Signature: _____