St. Clair County Community Mental Health

Audio/Visual Authorization

Case #: _____

I, _____ authorize, and consent is hereby given for the following: (Check all that apply)
(Individual or Parent/Guardian Name)

☐ Photographing ☐ One-Way Mirror ☐ Audiotaping

☐ Observation ☐ Videotaping ☐ Fingerprinting

of _____ at the following location (_____) for the purposes of
(Individual's Legal Name) (Location)

_____

_____

_____
(i.e., Treatment, Education, Therapist Training, etc.)

I understand that the material(s) will be erased/destroyed following their stated purpose(s). This consent is effective only for the period beginning on _____ and ending on _____ .
(Date) (Date)

I understanding that these materials will be treated as confidential information and will not be released/used by anyone other than St. Clair County Community Mental Health direct and contract personnel. I further understand that I will remain anonymous. Lastly, I understand that the material(s) will be erased/destroyed within effective dates of this consent.

I understand that I can withdraw my consent in writing at any time during this period.

I further understand that my signature does not waive my legal rights, including release of the program, or its agents, for liability for negligence.

_____ _____ _____ _____
Individual Legal Signature Date Parent/Guardian Legal Signature Date

_____ _____
Witness/Staff Member Legal Signature Date

Distribution:

1. Original copy scanned to Individual's chart.
2. Physical copy provided to Individual and/or Parent/Guardian.

Clinical Form: #03-0016
Revised Date: 1/13/2025
Policy Ref: #03-002-0025, #05-003-0010
EHR: Legal/Consents, Consent for Treatment Note: Audio-Visual Authorization