Sound Foundations
Professional Counseling
Where the building blocks
Of future successes are laid
Jason Soto MA, MFT
Individual, Couples & Family Therapist

Consumer Authorization for Audio Recording of Therapy Session

Client Name(s):____ Date of Birth __________

____ Date of Birth __________

____ Date of Birth __________

____ Date of Birth __________

I authorize Sound Foundations Professional Counseling to record by audio, my therapy sessions. I understand the recording will be used for the maintaining of accurate notes and for note taking purposes only.

I understand this is not part of my medical record and that I do not have access to the recordings. I understand the audio recording will be deleted as soon as the case note is typed (most often within 24hrs).

Client Signature____ Date_____________
(signature required for age 13 and older)

____ Date_____________
(signature required for age 13 and older)

____ Date_____________
(signature required for age 13 and older)

____ Date_____________
(signature required for age 13 and older)

Parent/Guardian Signature________________________________ Date_____________
(if applicable)

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