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 supervision and 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 stored in a secure location.

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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