THE PSYCHOLOGICAL TRAUMA CENTER
a division of Preventive Psychiatry Associates Medical Group, Inc.
2105 Divisadero Street
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VIDEOTAPING PERMISSION/RELEASE

This is to permit videotaping of consultation and/or treatment of the following patient's sessions by this Center:

Name of patient: ____________________________________

If this permission or release concerns a minor, I am the legal guardian of that minor.

☐ The videotapes may be used for scientific or educational purposes.

☐ The videotapes may not be used for scientific or professional educational purposes.

My name: ____________________________________

My signature: ________________________________

Today's date: ________________________________

DO NOT WRITE BELOW - PTC USE ONLY
Videotaping date: _____/_____/_____
Videotape #: ____________
Drawer #: ______________