

**Behavioral Consultation Services of Northern Arizona (BCSNA)**  
**906 W. University Avenue**  
**Suite 120**  
**Flagstaff, AZ 86001**  
**(928) 556-9935**

### **Consent for Audiovisual Recording**

#### **SECTION I**

(To be completed at the time of registration)

For the purposes of enhancing quality patient care and advancing behavioral knowledge, I, the undersigned, give permission to BCSNA to video record myself/child for the following purpose(s): (initial all numbers that apply)

\_\_\_\_\_ 1. To assist in evaluation and intervention. (These recordings may be made a part of the permanent record.)

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#### **SECTION II**

(To be completed when appropriate)

\_\_\_\_\_ 2. To assist in training professionals. (These materials may be edited, but the subjects will not be identified by name.)

\_\_\_\_\_ 3. For research purposes. (An additional consent form may be required and, if so, is included in the complete record.)

\_\_\_\_\_ 4. For publicity and public relations purposes. The specific purpose is \_\_\_\_\_.

\_\_\_\_\_ 5. Another purpose, which is (An additional consent form may be required and if so, is included in the permanent record.)

### SECTION III

I understand my decision regarding items 1-5 will not affect the quality of care given to my child through BCSNA. My decision regarding recordings used for evaluation and intervention may affect the choice of individual treatment plan developed for my child. A professional has discussed items 2-5 with me. I understand that I may preview final versions of these materials.

I understand that I may withdraw permission for continued recording and/or use by notifying BCSNA of my decision in writing.

Restrictions on recordings and use, if any.

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NAME \_\_\_\_\_ INITIALS \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_

PHONE NUMBER \_\_\_\_\_

RELATIONSHIP TO PATIENT/CLIENT \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

WITNESS \_\_\_\_\_ DATE \_\_\_\_\_

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### SECTION IV

I do not give permission for any visual or sound recording to be made of myself/child,  
\_\_\_\_\_ by staff of BCSNA.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

RELATIONSHIP TO CHILD/WARD \_\_\_\_\_

WITNESS \_\_\_\_\_ DATE \_\_\_\_\_