Dawn Wade, MA, ATR, CHT, LMFT

Licensed Marriage and Family Therapist
Certified Hypnotherapist Registered Art Therapist
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HIPAA Authorization

Procuring Images of Client Artwork/Release of Audio Recordings

I, _____ hereby give my permission and authorize Dawn Wade, ATR, CHT, LMFT to make and disclose photographic recordings of artwork and/or audio recordings of me/Client in accordance with the Healthcare Insurance Portability & Accountability Act (HIPAA) and other relevant regulations as outlined below.

Check and initial by the appropriate circle/listing. This consent limits the use and disclosure to the purposes only specified below:

- _____ I consent to photographing of artwork for my Client Medical Record.
- _____ I consent to audio recording being taken for the specific purpose of hypnotherapy or as described below. This consent does not extend to any further publication(s).
- _____ I consent to photographing of artwork _____ or audio recording_____ as written below:

  _____
  _____
  _____

I understand that the authorization of photo, and/or audio recordings for the specific purpose (described above) will be confidentially destroyed by (specify date; not to exceed 7 years):

_____
Date and initials

I understand that my specific and additional permission is required for any future use of these photo, video and/or audio recordings that extend beyond the expiration date.

I understand that I am not required to sign this Authorization. If I sign this Authorization, I may revoke/withdraw the Authorization at any time by giving notice to Dawn Wade, ATR, CHT, LMFT and the recorded images will be confidentially destroyed.

Your acceptance or denial of this authorization will not affect your treatment with Dawn Wade, ATR, CHT, LMFT.

_____ _____
Signature of Client or Authorized Representative Date

If Authorized Representative has signed on behalf of Client, state the authority of Authorized Representative to do so:

_____
(such as parent of a minor, court-appointed guardian, appointed in a Power of Attorney)