Darakjian Psychiatry

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# CONSENT TO VIDEOTAPE

I, _____, authorize Ara Darakjian, M.D. to videotape my psychotherapy sessions with him as an integral part of my consultation and psychotherapy. I understand that Dr. Darakjian is committed to studying the process of treatment in order to make psychotherapy more effective and efficient. To this end, I agree that my videotapes can be used for Dr. Darakjian's personal review and for his consultation with senior colleagues.

I understand that the use of my videotapes may occur only in accordance with the highest ethical standards of professional confidentiality for California mental health practitioners. I understand that my name will never be disclosed and that the tapes will be used solely for the purposes described above. I understand that the tapes are not part of my permanent medical record and that I may rescind this agreement or ask that all tapes be destroyed at any time.

_____ _____

Signature Date