The Alliance for Eating Disorders Awareness Psychological Services
1649 Forum Place, Suite 10
West Palm Beach, Florida 33401

Consent for Audio/Video Recording

I, _____, hereby give my consent and permission to The Alliance for Eating Disorders Awareness Inc, and its Psychological Services program (together, the "Alliance") to audio and video record psychological testing and all therapeutic interactions in which I am involved. It is my understanding that the purpose of the recording is for evaluation and training purposes. I understand that the supervisors of the trainees will have access to the audio/video recordings at any time. The recordings will be maintained on a secure server accessible only to the Alliance staff. I also consent to the use of any evaluations, surveys, or forms I fill out to be released to the Alliance for any use, including but not limited to evaluating and promoting the Alliance's Psychological Services program, provided my identity is not revealed to any third parties. . I agree to hold the Alliance and its agents and employees harmless of any liability in the proper and prudent use of the recordings and materials described herein.

_____

Printed Name

_____

Signature **Date**

_____

Witness **Date**