

**COMMUNITY INSTITUTE FOR PSYCHOTHERAPY**

**TAPING RELEASE FORM**

I fully understand that the services offered by Community Institute for Psychotherapy are rendered by Trainees, Associates, Pre-Docs or Post-Docs and are under the professional supervision of the staff of Community Institute for Psychotherapy. I understand that these sessions may be audio taped for purposes of training and supervision of the students. Use of these tapes will conform to the professional ethics governing professional behavior of psychologists and counselors. Full confidentiality of all matters discussed will be respected by the Community Institute for Psychotherapy staff and students. I further declare that I freely consent to and accept these services. The services may be any of the following: psychological testing, counseling, and/or psychotherapy.

Date: \_\_\_\_\_

Signed: \_\_\_\_\_

Witnessed by: \_\_\_\_\_  
(Trainee, Associate, Pre-Doc or Post-Doc)