Eclipse Mental Health Services

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CONSENT FOR AUDIO/VIDEO RECORDING

☐ I do ☐ I do NOT give my consent to be AUDIO/VIDEO recorded during any in office or telemedicine appointment.

_____ _____
Signature of Patient Date Signed

_____ _____
Signature of Parent, Legal Guardian or Conservator Date Signed

_____ _____
Signature of Witness (if appropriate) Date Signed

DISCLAIMER: By typing your name below, you are signing this application electronically. You agree your electronic signature is the legal equivalent of your manual signature on this document.