Service Name:……………………… Service Address……………………………

PATIENT INFORMATION ABOUT CONSENT for AUDIO/VIDEO RECORDING of PSYCHOLOGICAL THERAPY SESSIONS

There are many reasons why photographic, video or audio recording a particular condition, consultation or procedure is beneficial:

- To have a record of how a condition changes
- To assist in treatment
- To help train staff
- To help supervise the staff who are treating you
- To inform people about treatments available and what they involve

We must however, ensure the interests and well-being of our patients are paramount and we have a duty to keep information about patients confidential.

Before any recording takes place someone will explain to you the purpose of why this is being done and what the recording will be used for. You will then be asked to sign to confirm your agreement. You would normally be given at least 48 hours notice of the request to audio /video record to consider your choice. After signing the consent you will have the right to:

- Have any recording stopped if you request it or if it is having an adverse effect on the consultation.
- See the audio/video recording in the form which it is intended to be shown.
- Vary or withdraw consent at that stage – if you withdraw consent the video or audio recording will be destroyed as soon as possible.
- Agree to any proposed changes in the use of the recorded material.

If you withhold or withdraw your consent this will not in any way affect your treatment or your relationship with the clinicians treating you.

Where someone is unable to give consent, a person with parental responsibility may consent on their behalf.

All recordings will be stored securely in the same manner as a medical record.

You may withdraw your consent to the use of recording at any time, however, if published withdrawal of consent may not be possible. No fees are paid for publication.

You may ask for a relative, friend or nurse to be present during the recording.

AUDIO VIDEO RECORDING OF PSYCHOLOGICAL THERAPIES CONSENT FORM

NHS CHI Number: ………………… Patient's Name: ……………………………………

DOB: …………… Patient Address: …………………………..…………………………

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1 Agreement to record

I agree to allow the taking of video recording / audio recording of me on (*date:)*…………………………………………………………

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2 Recording as part of the clinical record

I understand that these recordings are part of my psychological therapy.

The recording will form part of my clinical record and will only be used in planning, delivering or reviewing my care. Once it is part of the clinical record I cannot ask for it to be removed.

Signed: …………………………………....   Date: …………………………..

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3 Recording of a group as part if the clinical record

I understand that these recordings are part of my psychological therapy.

The recording will form part of my clinical record and will only be used in planning, delivering or reviewing my care. Once it is part of the clinical record I cannot ask for it to be removed.

I am aware that copies of the recording will also form part of the clinical record of other people who participate in the group. I have been made aware that I will not be able to access this part of my clinical record because it will also contain images of the rest of the group.

Signed: …………………………………....   Date: ……………………

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4 Recording as part of supervision

I understand that these recordings will be used in the supervision of my therapist. I have been given written details about how these recordings will be used, where they will be kept and how long they will be kept for.

Signed: …………………………………....   Date: ……………………………

Copy to be stored in the patient file.

5 Recording for training purposes

I understand that these recordings will be used in the training of clinical and other care staff:

*specifically related to my care and treatment

*as part of a wider training programme.

*(* delete as applicable)*

I have been given written details about how these recordings will be used, where they will be kept and how long they will be kept for.

I understand that my consent can be withdrawn at any time but that if the recording has been submitted for as an academic assignment to an accrediting body it may not be possible to be destroyed.

Signed: ………………………………….... *Date:* ……………………………

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5 Recording as part of a research/audit project

I understand that these recordings will be used as part of a research project. I have received specific written information relating to what will happen to these recordings from the researcher. However, if the research is published withdrawal of consent may not be possible. No fees are paid for publication.

Signed: ………………………………….... *Date:* ……………………………

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6 Statement of NHS Board practice

Lothian NHS Board will use the recordings only in accordance with the above consent. It will ensure that recordings are made, stored and destroyed in line with Board Policy and best practice.

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7 Staff member signature

This consent process was explained to:

(patient)…….……………………………………..…………

by *(person undertaking recording) Name:* …………….…………………

Position: ……………………………………………………………..…

Signed: ………………………. *Date:*………………………………

Copy to be stored in the patient file.