Patient Consent to Record Clinical Sessions

Patient Name: _____ **Date of Birth:** _____

Date of Consent: _____

Purpose of This Form: Florida law (§ 934.03, Florida Statutes) requires **all-party consent** before recording any private communication. This form is to inform you, the patient, that your clinical sessions **may be recorded** (audio and/or video) and to obtain your **written permission**.

📌 Recording Details

- **Type of Recording (check all that apply):**
  - ☐ Audio only
  - ☐ Audio and Video

- **Purpose of Recording (check all that apply):**
  - ☐ Clinical documentation
  - ☐ Video Telehealth Remote Hearing Aid Programming

🔐 Confidentiality and Rights

- Your **privacy and confidentiality** will be protected in accordance with federal and state law. You may **refuse** to be recorded or **withdraw consent** at any time without affecting your care. You may request access to or deletion of your recordings, unless prohibited by applicable law or clinical policy.

- **How Recordings Will Be Stored and Protected:**
  Recordings will be stored securely in compliance with HIPAA. Only authorized personnel will have access.

✅ Consent: Please read and initial the following:

_____ I have been informed that my sessions may be recorded.
_____ I understand the purpose and type of recordings being made.
_____ I understand how the recordings will be used and protected.
_____ I give my voluntary consent to be recorded during clinical sessions.

Signature of Patient (or Legal Representative): _____

Print Name: _____

Relationship to Patient (if applicable): _____