ICEEFT Certification Video Release Form

Date: _____

I/We consent to the recording of my/our session(s) to be viewed by a representative of the International Centre for Excellence in Emotionally Focused Therapy (ICEEFT). I/We understand that this recording will be kept confidential and viewed only by an ICEEFT representative as part of the ICEEFT Certification procedure. The ICEEFT representative will also take responsibility for destroying the recordings after viewing them.

Client Name(s): _____

Client Signature: _____

Client Signature: _____

Therapist name: _____

Therapist Signature: _____