Kyra Grosman, Psy.D.
406 7th Avenue
Brooklyn NY 11215

I authorized Kyra Grosman, Psy.D. to make video recordings as an integral part of my treatment. I understand that Kyra Grosman is committed to studying the process of treatment in order to make my psychotherapy as effective, efficient, and successful as possible.

I understand that:

- ]I do not need to sign this authorization, in which case no recording will take place
- I will not be denied treatment if I choose not to sign this authorization
- I am entitled to a signed copy of this authorization.
- The use of these recordings will be restricted to the following purposes:
    - review and analysis by Kyra Grosman.
    - confidential consultation by Kyra Grosman with selected profession ISTDP therapist colleagues.
    - training of select professional therapists.
- The recordings will be used in accordance with the highest ethical stands of professional confidentiality for licensed mental health professionals. However, with the use of recorded material it is not possible to guarantee that I would not be identified.
- My name will not be revealed.
- These recording will not become the property of anyone other than Kyra Grosman.
- I will not receive financial compensation for the taping or use of these recordings.
- This authorization shall remain in effect until Kyra Grosman's retirement, or until revoked by me.
- I can request in writing at any time that the recordings themsevles be destroyed. Such requests will be effective immediately on my written request, but will not affect any action taken by Kyra Grosman prior to his receipt of the request.
- The tapes are not part of my permanent medical or insurance records and Kyra Grosman will erase each tape immediately after it has been used for its intended purpose.

I have crossed out and modified any aspects of this authorization that I wish to change.

Signed _____
Date _____
Name _____