INFORMED CONSENT TO VIDEO RECORD SESSIONS OF YOUR CHILD

The North Dakota Autism center is committed to providing high quality ABA services to clients and families. We are also committed to the teaching and training of staff furthering their skills and staff pursuing their certification in Applied Behavior Analysis. Video recording sessions can play a significant role in obtaining these goals and ensuring the delivery of high-quality services to both clients and caregivers. The North Dakota Autism Center would like to request permission to utilize video recordings during therapy sessions. Your signature below indicates that you give the North Dakota Autism Center permission to record your child, and that you understand the following.

Below are the terms and conditions in which video recordings will be utilized.

1. Purpose of recording will be utilized for caregiver training, client safety, monitoring staff performance, and trainings within the North Dakota Autism Center. Therefore, the recordings may be reviewed by the Owner & Executive Director, Clinical Director, Manager of Quality Assurance, Behavior Analysts and Behavior Technicians. If a prior release of information is granted, videos can also be shared with outside agencies such as outside therapies and/or providers (i.e. Speech, Occupational Therapy, Direct Service Providers) for the purposes of training.
2. The contents of recordings are confidential and will not be shared outside the context of which the purpose for reviewing the recording.
3. The recordings will be obtained on North Dakota Autism Center property and stored on the premises of the North Dakota Autism Center.
4. The contents of the videos will be shared via a Microsoft Teams.
5. A copy of recordings can be sent to you at your request.
6. Authorization may be revoked at any time. To revoke my authorization, I must notify the North Dakota Autism Center in writing.

Initial one of the following options regarding video recordings.

____ I provide consent for _____ to be video recorded during their ABA therapy sessions at the North Dakota Autism Center.

____ I DO NOT provide consent for _____ to be video recorded during their ABA therapy sessions at the North Dakota Autism Center.

INFORMED CONSENT TO VIDEOTAPE PEER INTERACTIONS

The North Dakota Autism center is committed to providing high quality ABA services to clients and families. These services often include social and play intervention with peer involvement. The goal of social and play intervention is for skills to generalize and maintain in different settings and with people outside of the intervention setting. Video recording sessions or live viewing sessions can play a helpful role in caregiver social and play training. Video recordings and/or live video viewing allows for caregivers to view their child engaged in target social and play skills with peers. The North Dakota Autism Center would like to request permission to utilize video recordings or live video sessions during your child's therapy sessions. Your signature below indicates that you give the North Dakota Autism Center permission to record your child engaged in peer interactions, and that you understand the following.

Below are the terms and conditions in which video recordings or live video sessions will be utilized.

1. Purpose of recording or live video session will be utilized for caregiver training, client safety, monitoring staff performance, and trainings withing the North Dakota Autism Center. Therefore, the recordings or live sessions may be reviewed/viewed by other caregivers of clients enrolled at the North Dakota Autism Center, Clinical Director, Manager of Quality Assurance, Behavior Analysts and Behavior Technicians.
2. I understand that my child or their likeness may be included in live sessions or recorded videos.
3. I understand that my child's first name may be included in live sessions or recorded videos.
4. I understand that pictures, videos, and my child's name are protected health information (PHI), and as such, are treated confidentially by the North Dakota Autism Center, their respective employees and agents, and those acting with North Dakota Autism Center's permission.

5. I understand that although my child or my child's likeness may be viewed by other caregivers of clients enrolled at the North Dakota Autism Center, that all additional information will be treated confidentially and therefore no other additional information will be provided.
6. The contents of recordings are confidential and will not be shared outside the context of which the purpose for reviewing the recording.
7. The recordings will be obtained on North Dakota Autism Center property and stored on the premises of North Dakota Autism Center.
8. The contents of the videos will be viewed on Microsoft Teams.
9. I understand that the contents of the video will be viewed in either a live session and/or during a parent check-in meeting and will remain the sole property of the North Dakota Autism Center.
10. Authorization may be revoked at any time. To revoke my authorization, I must notify the North Dakota Autism Center in writing.

Please initial one of the following options regarding Video Consent Peer Interactions
____ I provide consent for _____ to be viewed in videos in alignment with the description above.
____ I DO NOT provide consent for _____ to be viewed in videos in alignment with the description above.

If information has not been disclosed, consent regarding video recordings can be revoked at any time. I understand by providing the signature below, I have reviewed and agree to the selections made above. This agreement will be in effect 1 year from the date of signature.

Printed Name:

Relationship to Child:

Signature:

Date:
