**RECORDING AUTHORIZATION**

**TO CREATE, USE AND DISTRIBUTE AUDIO RECORDINGS FOR EDUCATIONAL PURPOSES ONLY**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
The signed document will be filed with the Coach and the client should also keep a copy.

**Please indicate your permission by circling and initialing each of the applicable choices below:**
 **EDUCATIONAL ACTIVITIES**
**Yes\_\_\_No\_\_\_\_N/A \_\_\_\_** I authorize, **the Coach** to make audio recordings of my coaching that document my role as a client to show said audio recordings for **educational purposes. I understand that the audio recordings may be shared as part of training and continued professional development in mentorship sessions with other health coaches who are bound by the same confidentiality rules.** I understand that there is a possibility that I may be identifiable in these sound recordings, though my name will **not** be published unless I specifically agree below. I grant this authorization as a voluntary contribution in the interest of health coaching education and knowledge.

**I DO\_\_\_\_\_\_\_I DO NOT** \_\_\_\_\_\_\_ consent to the use of my name **(FIRST NAME ONLY**) with these sound recordings or audio accounts.

I agree to release and hold harmless **the Coach** from any liability related to the making or use of these sound recordings or written/audio accounts for the purposes stated above. I understand that I may refuse to sign this authorization, and that my refusal to sign will not affect my treatment as a health coach’s client. I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance of this authorization. I understand that the information released may be subject to re-disclosure by some recipients and may no longer be protected by federal and state privacy rules related to health information. Authorization for all uses and disclosures indicated above will expire 10 years from the date of signature, however, I acknowledge **the Coach** is unable to control the continued use of sound recordings and digital copies by non-affiliated personnel after expiration of this authorization.

 **Signature of Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**To revoke this authorization,** please send a written request with a copy of this completed form to:
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have any questions, please call \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ .