Katherine E. Watkins MD
2999 Overland Ave, suite 201
Los Angeles, CA 90064
310-470-1534

CONSENT TO VIDEOTAPE

(Leave blank if you decline consent.)

I, ____________________________________, authorize Katherine Watkins, M.D. to videotape my psychotherapy sessions with her as an integral part of my consultation and psychotherapy. I understand that Dr. Watkins is committed to studying the process of treatment in order to make psychotherapy more effective and efficient. I understand that the use of my videotapes is limited and may occur only in accordance with the highest ethical standards of professional confidentiality for California mental health practitioners.

Viewing of my videotapes is strictly limited to the following:

(1) analysis by Dr. Watkins to optimize the quality of my care
(2) use by Dr. Watkins for the purpose of professional supervision about my treatment

I understand that my name will never be disclosed and that the tapes will be used solely for the purposes described above. I further understand that the tapes are not part of my permanent medical record and that Dr. Watkins will erase each tape after it has been used for its intended purpose.

____________________________________ ____________________

Signature Date