



Waves Music Therapy

www.wavesmusictherapy.org

Consent for recording and usage of visual images in Music Therapy

I / we consent to the person named below receiving music therapy,
as referred through Waves Music Therapy.

YES / NO

Name of Client: _____

Date: _____

Address: _____

Please circle below regarding whether or not you consent to the following statements regarding the making and usage of film footage and photographic material from these music therapy sessions.

1. Filmed material:

Film can be taken in sessions for the analysis by the therapist
and / or for them to work through with their clinical supervisor:

YES / NO

Film footage can be taken to share with other professionals and the family
to enable others to feel included in the therapy process and, where appropriate
included in professional presentations (with notification given.)

YES / NO

Clips from footage taken in sessions can be included on the
Waves Music Therapy web site to promote music therapy:

YES / NO

2. Photographic material:

Photos can be taken in sessions for use (not web-based)
by Waves Music Therapy:

YES / NO

Photos can be taken in sessions for use on the Waves Music Therapy
web site www.wavesmusictherapy.org to promote music therapy:

YES / NO

Name of parent / carer if appropriate: _____ Signed: _____ Date: _____

Relationship to the client: _____ E-mail address: _____

Please return the completed form to the Music Therapist. Thank you.