Date: _____

We consent to the recording of our session(s) to be viewed by a representative of the International Centre for Excellence in Emotionally Focused Therapy (ICEEFT). We understand that this recording will be kept confidential and viewed only by a Certified EFT therapist as part of the ICEEFT Certification procedure. The ICEEFT representative will also take responsibility for destroying the recordings after viewing them.

Client (s) Name: _____

Client Signature: _____

Client Signature: _____

Therapist name: _____

Therapist Signature: _____