



### Permission to show patient video and/or play patient audio

I, \_\_\_\_\_ (name of patient), hereby give permission to \_\_\_\_\_ (name of professional) to show videotaped or play audio taped interview(s) of me to attendees at the 33<sup>rd</sup> Annual International Conference of the International Society for the Study of Trauma and Dissociation, being held 31 March – 4 April 2016 in San Francisco, CA, USA. I understand that personal material will be used *only* for educational purposes and that the videotape or audio tape material will NOT be rerecorded at the conference for later distribution.

Name of Patient: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

### Alternate Attestation:

I, \_\_\_\_\_ [name of professional] affirm and attest that I **previously** obtained **written or verbal** permission to use audio or videotaped materials of patient \_\_\_\_\_ [name of patient] but that this person is not available to **re-execute** the above waiver. I take responsibility for using this material in accordance with the ethical guidelines of my profession and hold ISSTD harmless for any claims of violation of confidentiality that may arise.

Name of Professional: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

Return to ISSTD Headquarters:

Email: [info@isst-d.org](mailto:info@isst-d.org)

Fax: 703-610-0234

Or Mail:

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McLean, VA 22102

USA