DEPARTMENT OF HEALTH SERVICES
Division of Long Term Care
Division of Mental Health and Substance Abuse Services
F-22538 (Rev. 07/2008)

STATE OF WISCONSIN
ss51.61(1)(o)
DHS 94.18

CONSENT TO FILM OR RECORD

Name – Client / Patient (Last, First MI)	ID Number	Name – Institution

By my signature below, I authorize the filming / recording as listed; and I understand that I may view the photograph or film or hear recording prior to any release. This consent may be revoked at any time by giving written notification to the institution director.

Type of Filming / Recording ☐ Photograph ☐ Video Tape ☐ Audio Tape ☐ CD	Date – Consent Expires
Name – Individual / Group Doing the Filming / Recording	
Purpose / Reason for Filming / Recording:	Resulting Materials Can Be Used By:

I further understand that I may specify periods during which or situation in which client / patient may not be filmed or recorded. I understand that neither last names nor other identifying information will be used or made available.

Filming / Recording Limitation – Times / Situations:

SIGNATURE – Client / Patient – If Presumed Competent		Date—Signed
SIGNATURE – Parent for Child (Minor) or Guardian	Relationship	Date—Signed

Distribution: Original—Patient Record