|  |  |  |
| --- | --- | --- |
| DEPARTMENT OF HEALTH SERVICESDivision of Care and Treatment ServicesF-22538 (11/2021) |  | STATE OF WISCONSINWisconsin Statutes § 51.61 (1) (o)Wis. Admin. Code § DHS 94.18 |
| **CONSENT TO PHOTOGRAPH OR RECORD AND USE OF PHOTOGRAPHS/RECORDINGS** |
| Name – Client or Patient (Last, First MI) | ID Number | Name of Facility or Institution |
|               |       |       |
| Type of Photograph and/or Recording | Date Consent Expires |
| [ ]  Photograph [ ]  Video [ ]  Audio |       |
| Name of Individual or Group Doing the Photograph and/or Recording |
|       |
| Purpose and/or Reason for Photograph or Recording | Resulting Materials Can Be Used By |
|       |       |
| Photograph and/or Recording Limitation – Times / Situations |
|       |
| By my signature below, I consent to being photographed and the use of photographs as listed. I further understand all of the following:* I authorize the photograph and/or recording as listed; and I understand that I may view the photograph or video or hear recording prior to any release.
* I may specify periods during which or situation in which I may not be filmed or recorded.
* I understand that my last name or other identifying information may be used or made available.
* I may revoke this consent at any time by giving written notification to the facility or institution director.
* I understand that DHS cannot control who saves and/or uses photos published on the Internet.
* I, nor any other person for whom I have given consent, will ever receive compensation for the use of any photograph.
* My decision to consent or not consent does not in any way affect eligibility for any Department programs, benefits or services.
 |
| **SIGNATURE** – Client or Patient If Presumed Competent | Date Signed |
|  |  |
| **SIGNATURE** – Parent for Minor Child or Guardian | Relationship | Date Signed |
|  |       |  |