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| DEPARTMENT OF HEALTH SERVICES  Division of Care and Treatment Services  F-22538 (11/2021) | | |  | | | | STATE OF WISCONSIN Wisconsin 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 | |
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