

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 <input type="checkbox"/> Photograph <input type="checkbox"/> Video <input type="checkbox"/> Audio		Date Consent Expires
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

DISTRIBUTION: Original – Patient Record

WRC DISTRIBUTION: Original – Event Coordinator and/or Department Head; Copy – Inmate