CONSENT TO PHOTOGRAPH AND FILM RESIDENT AND ARTWORK

To be Completed and Signed by the Resident, Parent/Guardian

PLEASE CHECK THE ITEMS YOUR PERMISSION IS GIVEN

1. _____to take and use photographs, slides, or films of myself as part of the treatment process and staff training.
2. _____to take and use photographs, slides, or films of my anonymous artwork as part of the treatment process and staff training.

I understand that I have the right to be protected under the Federal Confidentiality Law and I do give my permission freely and of my own accord.

I understand that I may revoke this consent for release of information at any time. However, I also understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of right to confidentiality.

If no date of revocation is specified, this consent will expire 1 year from the date of signature below.

_____ _____

Resident Signature Date

_____ _____

Parent/Legal Guardian Signature Date

_____ _____

Witness Signature Date

Resident's Name: _____

Resident's Record No.: _____

Resident's Date of Birth: _____

Resident's CIHA Record No.: _____