St. Clair County Community Mental Health

Authorization/Consent for Newsletters, Annual Reports, Public Relations, and Related Uses

Case #: ____ Date:_________________________

Birthdate: _____________________________________

I, _________________________, hereby authorize St. Clair County Community Mental Health, its successors, legal representatives and assigns to photograph or audio record me.

I also authorize, for information purposes, use and/or reproduction of these materials for thirty (30) years.

I understand these materials may be used in audio-visual presentations or publications regarding services provided by or through St. Clair County Community Mental Health.

I also understand that a written story about me may appear with photographs or audio recordings.

I have no objective to the use of my photographs or audio recordings for the purposes described.

____ ____

Witness | Signature

____

Address, City, State, Zip

____ ____

Witness | Parent/Guardian Signature (for persons aged 17 or younger)

____

Address, City, State, Zip

My name may be used in conjunction with the photographs, audio recordings, and stories.
_____Yes _____No __________Initials