Sheppard Pratt
HEALTH SYSTEM

ADDRESSOGRAPH

RELEASE AND CONSENT FOR VIDEO, AUDIOTAPE AND DIGITAL RECORDINGS, PRINTED MATERIALS, PHOTOGRAPHS, AND INTERNET TRANSMISSIONS

I/We hereby give my/our permission to the Sheppard Pratt Health System, Inc. and all its subsidiaries and affiliates (hereinafter SPHS) through its employees and agents to record on videotape, audiotape, film, and/or digitally, to reference or cite in any printed medium my/our activities, interviews, or publications in which I/we may take part, to permit the public display of any recordings, photographs, films or the publication of any printed matter for any of the following purposes:

- ❑ Treatment purposes;
- ❑ Mental health or related education and training programs;
- ❑ Use by clinicians in supervision;
- ❑ Academic / school related activities and purposes;
- ❑ Fundraising, promotional activities, or marketing (may include Internet transmission, i.e. social media);
- ❑ Other: Specify _____

I/We agree that SPHS or its agents shall be the sole owner or owners of all rights to such recordings, film, or printed materials. I/We give this consent and release with full understanding that the use of the materials by SPHS or any of its agents may result in the disclosure of my/my child's identity and/or the fact of my/my child's treatment to third parties. I/We further understand that information about me/us which is disclosed by this authorization may be redisclosed by recipients of the information without any limitations. I/We hereby release any claim or right that I/we might have against SPHS and its agents in connection with the making, displaying, or publication of these materials.

This consent is given of my/our own free will in consideration of my/our interest in improving therapeutic programs, in advancement of the training and education of mental health and related personnel, and to assist SPHS in academic, fundraising, promotional and marketing activities. I/We understand that my/our execution of this consent is **not** a condition of my/our receiving services from SPHS and that I/we may revoke my/our consent at any time by written request to _____

at _____.

This authorization is valid for any recordings, photographs, films interviews, or publications made within a period of one year from the signature date indicated below. For purposes related to SPHS school programs, the authorization is valid for any recordings, photographs, films interviews, or publications made within the duration of my/my child's enrollment in the school. I/We understand that recordings, photographs, films, interviews, or publications which are created on the basis of this authorization may continue to be utilized, distributed or reproduced after the period during which they are made under this Release and Consent and/or after the Consent is withdrawn. I/We acknowledge receipt of a copy of this Consent.

WITNESS SIGNATURE	PRINTED NAME	DATE
SIGNATURE	PRINTED NAME	DATE
SIGNATURE OF PARENT / GUARDIAN IF MINOR	ACTUAL USAGE	

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