

County of San Bernardino Department of Behavioral Health
CONSENT TO RECORD AND/OR PHOTOGRAPH AND
AUTHORIZATION FOR USE OR DISCLOSURE

Name of Client: _____	Date of Birth: _____ Month/Day/Year
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security: _____ - _____ - _____

Completion of this document authorizes the release, disclosure, and/or use of sound and photographic recordings of you. Failure to provide all information requested may invalidate this Authorization.

USE AND DISCLOSURE OF SOUND AND/OR PHOTOGRAPHIC RECORDINGS

I hereby agree that the San Bernardino County Department of Behavioral Health (DBH) including Alcohol and Drug Services Administration may use photographs and/or sound recordings of my presentation/participation in DBH and/or County sponsored events.

The term "photograph," includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.

I hereby authorize _____ to release to:

(Facility Name/Provider/Other)

Name: _____

Address: _____

Phone Number: _____

PURPOSE

I hereby authorize the use or disclosure of the photograph(s) and/or sound recordings for the following uses or purposes (describe permitted uses, e.g., use by Department of Behavioral Health (DBH) Mental Health and/or Alcohol and Drug Programs, clinicians, staff, and members of the public for educational, treatment, research, public relations, and charitable purposes):

I consent to be photographed and/or recorded and authorize the use or disclosure of such sound and/or photographic recording(s) in order to assist research, treatment, educational, public relations, and/or charitable goals, and I hereby waive any right to compensation for such uses by reason of the foregoing authorization. I and my successors or assigns hereby hold DBH, its staff, the County, and any other person participating in my care and their successors and assignees harmless from and against any claim for injury or compensation resulting from the activities authorized by this agreement.

EXPIRATION

This Authorization expires [insert date]: _____

County of San Bernardino Department of Behavioral Health
CONSENT TO RECORD AND/OR PHOTOGRAPH AND
AUTHORIZATION FOR USE OR DISCLOSURE

MY RIGHTS

- I may refuse to sign this Authorization. It will not affect my ability to get treatment.
- I may request filming or recording stop at any time.
- I have a right to receive a copy of this Authorization.
- To the extent permitted by law, I may inspect or obtain a copy of the photograph and/or sound recording whose use or disclosure I am authorizing.
- I may revoke this authorization at any time, but must do so in writing and submit it to the following address: _____

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Consent and Authorization.

Information disclosed by this Authorization could be re-disclosed by whoever receives it, and the re-disclosed is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

SIGNATURE

Date: _____ Time: _____ am pm

Signature: _____

(patient/representative/spouse/financially responsible party)

If signed by someone other than the client, state your legal relationship to the client:

Witness: _____
