St. Clair County Community Mental Health Authority

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

Case #: _____ Date: _____

Birthdate: _____

I, _____, hereby authorize St. Clair County Community Mental Health Authority, 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 Authority.

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