

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH

Authorization for Taking/Use/Disclosure of Photographs, Audiotapes, and/or Videotapes
(continued)

Name of person/agency to photograph, audiotape, and/or videotape: _____

I understand that I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization. If I revoke this authorization, I must do so in writing and present it to DMH at the address below. The authorization to photograph, audiotape, and/or videotape me as specified in this authorization will expire on _____ (specify a date, time period or an event) or, if nothing is specified, it will expire in 12 months. Similarly, the authorization to use the photograph(s), audiotape(s) and/or videotape(s) will expire _____ (specify a date, time period, or an event) or, if nothing is specified, they may be used indefinitely.

I understand that if I have authorized the release or use of the photograph(s), audiotape(s) and/or videotape(s) outside of DMH, the recipient may use and redisclose them and the items may not be protected by federal or state privacy laws or regulations. I understand that authorizing the use or disclosure of the items identified here is voluntary. I need not sign this form to receive treatment or services from DMH.

Your signature or Personal Representative's signature

Date

Print name of signer

THE FOLLOWING INFORMATION IS NEEDED IF SIGNED BY A PERSONAL REPRESENTATIVE

Type of authority (e.g., court appointed, custodial parent): _____

INSTRUCTIONS:

1. This form must be completed in full to be considered valid. All five (5) items listed on the first page must be addressed in the narrative section.
2. Distribution of copies: original to appropriate DMH record; copy to person, facility or agency doing the photography, etc.; copy to individual or Personal Representative.