**DEPARTMENT OF HEALTH SERVICES**
Division of Care and Treatment Services
F-22538 (11/2021)

**STATE OF WISCONSIN**
Wisconsin Statutes § 51.61 (1) (o)
Wis. Admin. Code § DHS 94.18

# CONSENT TO PHOTOGRAPH OR RECORD AND USE OF PHOTOGRAPHS/RECORDINGS

| Name – Client or Patient (Last, First MI) | ID Number | Name of Facility or Institution |
|---|---|---|
| | | |

| Type of Photograph and/or Recording | Date Consent Expires |
|---|---|
| ☐ Photograph ☐ Video ☐ Audio | |

| Name of Individual or Group Doing the Photograph and/or Recording |
|---|
| |

| Purpose and/or Reason for Photograph or Recording | Resulting Materials Can Be Used By |
|---|---|
| | |

| Photograph and/or Recording Limitation – Times / Situations |
|---|
| |

By my signature below, I consent to being photographed and the use of photographs as listed. I further understand all of the following:

- I authorize the photograph and/or recording as listed; and I understand that I may view the photograph or video or hear recording prior to any release.
- I may specify periods during which or situation in which I may not be filmed or recorded.
- I understand that my last name or other identifying information may be used or made available.
- I may revoke this consent at any time by giving written notification to the facility or institution director.
- I understand that DHS cannot control who saves and/or uses photos published on the Internet.
- I, nor any other person for whom I have given consent, will ever receive compensation for the use of any photograph.
- My decision to consent or not consent does not in any way affect eligibility for any Department programs, benefits or services.

| **SIGNATURE** – Client or Patient If Presumed Competent | | Date Signed |
|---|---|---|
| | | |
| **SIGNATURE** – Parent for Minor Child or Guardian | Relationship | Date Signed |
| | | |

DISTRIBUTION-Original-staff to scan to DHS Connect / Informed Consents/Consent Forms / Title-date ; Copy- Resident/Client/Patient upon request