



CONSENT TO THE USE OF PHOTOGRAPHY, AUDIO/VIDEO TAPE RECORDING, OR VIEWING THROUGH ONE-WAY GLASS

Recipient Name _____ NLCMH Case # _____

I, _____

Voluntarily authorize Northern Lakes Community Mental Health Other _____

- (check those that apply):
- To take my (or my ward's or child's) photograph;
 - To make an audio-tape recording of my (or my ward's or child's) voice;
 - To make a video-tape recording of me (or my ward or child).
 - To view me (or my ward or child) through one-way glass

The purpose for the photograph, audio/video recording, or use of one-way glass is:

- (check those that apply):
- As an essential means of identifying me (or my ward or child)
 - For exclusive use in therapy.
 - For use in evaluation and assessment of psychological testing.
 - For use in NLCMH approved research.
 - For use by North Central CMH in staff/intern training and development.
 - For use by the following public news media: _____
 - Other (specify): _____

Except for photographs or tapes taken by public news media, any photograph or audio/video recording will be treated as confidential and will be secured in my (or my ward's or child's) clinical record. I also understand that this consent is only valid for ninety (90) days from the date of my signing. The photograph, digital image, or audio/video recording will be given to me or destroyed when no longer necessary for the purpose it was authorized.

CONSENT

I have read and understand the information in this agreement or it has been clearly explained to me in a way I can understand. I voluntarily agree to this agreement with the understanding that I am free to withdraw my consent at any time without prejudice by signing the withdrawal of consent portion of this form below or by notifying Northern Lakes Community Mental Health by registered letter to the Chief Executive Officer.

Signature: _____ Date: _____
(Recipient)

Signature: _____ Date: _____
(Empowered Guardian, or Parent of a Minor)

Signature: _____ Date: _____
(NLCMH Representative or Witness)

WITHDRAWAL OF CONSENT

Signature: _____ Date: _____
(Recipient)

Signature: _____ Date: _____
(Empowered Guardian, or Parent of a Minor)

Signature: _____ Date: _____
(NLCMH Representative or Witness)

Copy to clinical record