# Photo, Video, and Audio Recording

# AUTHORIZATION AND RELEASE

***You have the right to refuse to sign this authorization. Participation is voluntary. DSHS will not withhold treatment, benefits or payment processing if you refuse to sign this authorization. If you are an employee of DSHS, refusal will not impact your employment status.***

For the benefit of Texas Department of State Health Services (DSHS) programs, I grant DSHS permission to photograph, audio and video record me for the purposes of program development, education and promotion. I grant DSHS and all persons or corporations acting with the permission or upon the authority thereof, permission to publish and publicly exhibit the photographs, audio and video recordings in any lawful and legitimate manner for the purposes set out above.

This material may be used for the purpose of:

* Training and education
* Public information
* Local news and promotion

I understand that the materials produced are the exclusive property of DSHS, and I hereby relinquish all rights, title and interest therein, and give DSHS my consent to retain, reproduce and use the material as authorized. I agree to release, discharge, and hold harmless DSHS and all persons or corporations acting with the permission or upon the authority thereof from any and all claims, causes of action, and demands in connection with use of my image or audio recordings as authorized herein.

DSHS is not responsible for parties not under its control who attend public events and take photographs or make recordings of individuals who voluntarily participate in public events.

## Your right to revoke this authorization

At any time, you can refuse to be photographed, audio and video recorded. You can also revoke this authorization. To revoke authorization, you, your parent or your guardian must deliver a written and signed statement to the department to which you originally gave authorization.

**Note:** Revocation or expiration of this authorization does not mean that DSHS will remove your photographs or recordings from materials created while the authorization was in effect. DSHS will make every effort to no longer use your photographs and recordings in materials created after you revoke this authorization.

I represent that I am at least 18 years of age and am fully competent to sign this release, or that I am the parent or guardian of the subject and I am authorized to sign this release on their behalf:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subject’s Full Name and Relationship to Signatory: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DSHS Employee Position (If Applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:

Date:

Received and accepted on behalf of the Texas Department of State Health Services by:

Printed Name and Unit