CDS Family & Behavioral Health Services, Inc.

Photo Release Authorization

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give permission to have my photograph,

(Print name as you would want it to appear if published)

name and/or videotape recording appear in CDS Family & Behavioral Health Services, Inc. media promotions including but not limited to publications, newspapers, web site, and/or television. I am aware CDS’s brochures, pamphlets, Public Service Announcements, and/or Press Releases, which may contain my photograph, may be distributed to target groups as well as the general public for the purpose of providing information or education related to CDS programs.

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Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent signature (If under 18 years of age**) Date

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Mailing Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address