Commonwealth of Massachusetts
Department of Mental Health
Authorization for Public Media

1. Consumer Information

Name: _____ Phone: _____

Street: _____ Date of Birth: _____

City/Town: _____ State: _____ Zip Code: _____

Authorization for Public Media: I authorize the Department of Mental Health (DMH) to photograph, audio and/or video record me for public media, publication and broadcast. I authorize DMH to use and disclose my name, and any and all photographs and audio and/or video recordings of me and/or including me in public media, publications and broadcasts, such as news articles, television, internet, social media, and other communications channels and in the planning, promotion, and production of publications and broadcasts.

I agree to discuss my personal experience with mental illness and/or have my photograph taken and/or be audio and/or video recorded for public media, publication and broadcast. **This authorization does not include the use or disclosure of my HIV test results or substance use disorder information or records protected by Federal Confidentiality Rules 42 CFR Part 2.** I will not disclose such information in any discussion, photograph or any audio and/or video recording.

I understand that:

- I may refuse to speak about any issue that I am uncomfortable with.
- I have the right to refuse to have my picture taken and/or be audio and/or video recorded.
- 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 Commissioner's Office, 25 Staniford Street, Boston, MA 02114. Include the name and location of your DMH contact.
- Once the above information or any picture, audio and/or video recording is released, the recipients may redisclose it and the information may not be protected by federal or state privacy laws or regulations.
- Authorizing the disclosure of the information identified above is voluntary.
- I need not sign this form to receive treatment or services from DMH.

This authorization to photograph, audio and/or video record me will expire (specify a date, time period or an event) _____or, if nothing is specified, it will expire one year from date of signing. Unless revoked, as set forth above, this authorization to use and disclose my name, and any and all photographs and audio and/or video recordings of me will remain in effect indefinitely.

2. Signature / Authorization: **Sign and provide information as required below**.

_____ _____

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. Distribution of copies: original to appropriate DMH record; copy to individual or Personal Representative.
2. A copy of this authorization shall be considered as valid as the original.