DSHS
WASHINGTON STATE
Department of Social and Health Services

# Video / Photo Release

| Date |
| --- |
| Photographer's Name |

I, _____, hereby authorize and consent to the use of my image
Printed Name
(photograph or video) by the Washington State Department of Social and Health Services for:

☐ Appropriate general use.

☐ This specific use:

I give this consent with no claim for payment.

| Signature | Date |
| --- | --- |
| Telephone Number (include area code) | Email Address |

**If the subject is a minor or an adult who has a legal guardian, the following section must be completed by a parent or guardian.**

| Guardian's Printed Name | Telephone Number (include area code) |
| --- | --- |
| Signature | Date |