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
Printed Name
my image (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	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