

Photo Release

DATE
PHOTOGRAPHER'S NAME

I, _____, hereby authorize and consent to the use of my visual 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)
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Complete the information below only if subject has a guardian or is a minor child.

GUARDIAN'S PRINTED NAME	TELEPHONE NUMBER (INCLUDE AREA CODE)
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SIGNATURE	DATE
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