MEDIA RELEASE CONSENT FORM

Name(s): ____ County: ______________

Address: ____ Phone: ________________

Street/Apt #

____

City/State/Zip Code

I authorize District Health Department #10 to release the following information of the named individual to public media sources:
Interview/Statements   Photographs   Video   Other: _____________

I authorize District Health Department #10 to utilize the following information on agency materials including but not limited to print media, electronic media, social media, etc.:
Interview/Statements   Photographs   Video   Other: _____________

I am 18 years or old.

I authorize you to use my name and county of residence.

DHD#10 has the right to continually use the approved information, unless I withdraw my authorization. My signature below means that I have read this form and/or had it read to me and explained in a language I understand.

____ ______________________

Signature of Parent/Guardian/Client   Date

A COPY OF THIS SIGNED FORM SHALL BE CONSIDERED VALID FOR AUTHORIZING RELEASE OF INFORMATION.

Rev_06.09.2017_JT