
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 older.

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.**