DDAWNY

DEVELOPMENTAL DISABILITIES ALLIANCE OF WNY

Consent to Photograph, Film, or Videotape

Name: _____

I hereby give permission to the Developmental Disabilities Alliance of Western New York (DDAWNY) to use any photographs or videos of myself including participation in interviews and the use of testimonials for the sake of marketing, publicity, and/or social media. I also grant DDAWNY the right to edit, use and reuse said products including use in print, Internet (including social media or website) and all other forms of media. I understand names may be used in communications or marketing materials. I also hereby release DDAWNY from all claims, demands and liabilities in connection with the above.

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), DDAWNY may not use or disclose certain Protected Health Information (PHI) without authorization. PHI includes, but is not limited to, photographic, audio, video, and other images.

By signing this form, you are authorizing DDAWNY to use and disclose such information for the purposes outlined.

I understand that once PHI is disclosed, DDAWNY cannot control further disclosures by the recipients of the information. I have been informed that I am under no obligation to sign this form. I have signed this form voluntarily. I understand that this authorization will be effective until the date referenced below.

_____Signature (self or legal guardian) _____Date

Expiration 1/1/2036

___No, I do not give consent