

**WMU-CENTER FOR DISABILITY SERVICES**  
**Authorization to Take and Use Photographs, Video Tapes, and/or Sound**  
**Recordings.**

I, \_\_\_\_\_ give WMU-CDS permission to \_\_\_\_\_ for the purpose of \_\_\_\_\_. I am aware that I can revoke this authorization at any time.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Consumer/Authorized Representative)

Authorized Representative's relationship to consumer: \_\_\_\_\_

If signed by the consumer as his/her own guardian, this consent must be signed by a witness.

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

The witness is responsible to assure that if the client signs s/he is competent to give informed consent (R330.7003) Michigan Department of Mental Health Administration Rules, if guardian signed, documentation is on file indicating that the court has empowered the guardian with the authority. If the witness does not feel the client is competent, refer to R330.601 1(3)-(4). Further release of information so disclosed is prohibited unless consistent with the authorized purpose stated above. Any persons receiving such information shall be so advised. (Section 748 © of Act 258, Public Acts of 1974, as amended). Privileged communication shall not be disclosed in civil, criminal, legislative, or administrative case proceedings unless the patient has waived the privilege or certain circumstances exist such as relevant physical or mental conditions, determination of competency, action arising from treatment, or a court order. (Specified circumstances can be found in Section 750 of Act 248, Public Acts of 1974, as amended).

- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain services/treatment.
- I understand that I may withdraw my authorization at any time. I understand also that such withdraw of my authorization may not be effective to prevent disclosure of information previously authorized or to stop previous action that has been taken in reliance on this authorization.
- I understand that, if the person or entity receiving this information is not covered by the Federal Privacy Regulations, such information may no longer be protected from further disclosure (Unless it is also covered by the Substance Abuse Confidentiality Act - 42 CFR Part 2: Further disclosure prohibited).
- My signature means that I have read this form and/or have had it read to me and explained in language I can understand. I know what information will be disclosed and give my voluntary consent to its release.
- All the blank spaces have been filled in except for the spaces reserved for my signature, signature of witness, and dates.

This authorization is in effect from \_\_\_\_\_ to \_\_\_\_\_.