

**Photography/Video/Interview Release Form**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (please print)

This authorization permits Central Michigan University or its media representative to photograph, film, or voice record me and to use my photos, videos, sound recordings, as well as my name and/or comments about its programs for educational and/or public relations purposes.

I understand that it may be used to promote CMU’s programs and colleges. Promotion may include but is not limited to, editing and reproduction for print articles and brochures, print advertising, and/or broadcast via print, Internet, radio, television, and social media.

I understand that my name, my picture, or other details that would disclose my identity may be revealed.

I understand that these recording may depict details of my educational or healthcare records.

I understand that signing this form is voluntary and if I don’t sign it, this will not affect the commencement, continuation, or quality of services provided to me.

I understand that I can revoke this authorization at any time in order to prohibit future use of my images/interviews, etc., by providing written notice to Central Michigan University Office of University Communications 305 Hopkins Court, West 201, Mount Pleasant, MI, 48859 or emailing ucomm@cmich.edu. The revocation will be effective immediately upon CMU’s receipt of written notice, except that the revocation will not have any effect on any action taken by CMU in reliance on this Authorization before it received my written notice of revocation.

I understand that this revocation will remain in effect for a period of five (5) years from the date of my signature.

**Please provide your contact information** in the event that CMU needs to contact you regarding this authorization:

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have read and understand the terms of this authorization, and I have been given an opportunity to ask questions about CMU’s use of my health information for possible use in broadcast or publication. I find these terms acceptable and hereby consent to the release of my name, photo/video, sound recording and comments as specified above. **Further, I request that CMU send a copy of this agreement to my email listed above.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

**If subject is under the age of 18, parent or guardian signature is required.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/guardian signature