



**AUTHORIZATION AND RELEASE  
TO USE PHOTOGRAPHS AND/OR INFORMATION**

I, \_\_\_\_\_, hereby authorize the North Carolina Department of Health and Human Services, and to any of its Offices or Divisions, referenced collectively as DHHS, to use, reproduce, and/or publish the following: (Check all that apply)

- Name
- Photograph
- Interview
- Written statement
- Video recording (digital or tape)
- Voice recording

Description of proposed content: Stories about impact of the Americans with Disabilities Act (ADA).

for the purposes of: (Check all that apply)

- Advertising DHHS programs and services in all media
- Press release to major media outlets, print or broadcast
- Posting on social media, including Facebook®, and Twitter®
- Educational, research or recruitment materials/publications
- DHHS newsletter
- DHHS websites
- Other (please specify) sharing with the Southeast ADA Center for release to multiple social media outlets and posting to websites.

Restrictions: (RESTRICTIONS WILL NOT APPLY UNLESS CHECKED AND INITIALED)

- \_\_\_\_\_ Do not use my real name.
- \_\_\_\_\_ Do not use any information that would reveal my residence.
- \_\_\_\_\_ I reserve the right to review information prior to use, and to withdraw this consent if I change my mind after review.
- \_\_\_\_\_ Other (please specify) \_\_\_\_\_.

I hereby hold harmless, release and forever discharge DHHS from any demands or causes of action which I, my heirs, representatives, executors and any other person acting on my behalf or on behalf of my estate may have as a result of the use of these materials. I waive any and all copyright or license rights I may have in the materials. This authorization and release is continuous and may only be withdrawn by my specific rescission of this authorization.

I am:

- Of legal age, over the age of 18, and sign this document on my own behalf, fully understanding that my consent is voluntary and that the services I receive from the Department are not conditioned upon my signing this form.
- The parent/legal guardian of the minor whose information is being released, and sign this document on behalf of said minor, fully understanding that my consent is voluntary and that the services received from the Department are not conditioned upon my signing this form.

Name (print)	Signature	Date
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Parent/Legal Guardian Name (print)	Signature	Date
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Witness Name (print)	Signature	Date
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