N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SERVICES FOR THE BLIND
INDEPENDENT LIVING REHABILITATION

AUTHORIZATION TO PHOTOGRAPH/ USE PHOTOGRAPH/ INTERVIEW

Date: _____

This authorization is expressly intended to release the NC Department of Health and Human Services (DHHS), Division of Services for the Blind (DSB) and its personnel from any and all liability that would result from the taking and authorized use of these materials.

I hereby authorize the above named to obtain or to permit:

The **North Carolina Division of Services for the Blind** to obtain the following of me/my child (check appropriate descriptions(s)

Photographs ☐ Film/Videotape ☐ Interview ☐ Voice Recording ☐

I agree that the above named may use or permit others to use the materials produced from this session for any of the purposed outlined below. (Check appropriate categories).

Educational Publications ☐ Division Publications ☐ Research Materials/Publications ☐
Print or Broadcast Media ☐ Advertising ☐ Web Site ☐

I agree that my name can also be used. Yes ☐ No ☐

_____		_____
Name (please print)	Signature	Date

_____	_____	_____	_____
Parent or Legal Guardian Signature (if applicable)	Date	Witness Signature (if required)	Date

Please return to: North Carolina Division of Services for the Blind