



## Video, Camera Release Form

|                        |         |
|------------------------|---------|
| MFP Participants Name: |         |
| SS# (last 4 digits):   | XXX-XX- |

The signature (or X; if X'd, witness must sign Witness section) below indicates my understanding of, and permission for, Department of Health and Human Services/Division of Medical Assistance/Money Follows the Person Project to use video footage and/or picture images recorded during my transition process.

My name may \_\_\_\_\_ or may not \_\_\_\_\_ (initial one) be used in association with this video recording and/or picture images.

This video footage and/or picture image may be used for the following purposes:

- Conference presentations
- Educational presentations
- Informational presentations
- Outreach, marketing, and promotion for MFP and home and community based services
- Personal copy given to MFP Participant

I will be consulted about the use of the video recording and/or picture image for any purpose other than those listed above.

There is no time-limit on the validity of this release nor is there any geographic specification of where these materials may be distributed.

This release applies to video footage and picture images collected as part of the content recorded for the Money Follows the Person project.

I do not wish to be video taped/pictures taken.

I have been, or will be, given a copy of this release form for my records.

|                         |   |         |  |     |
|-------------------------|---|---------|--|-----|
| Name (please print):    |   | Date:   |  | / / |
| Signing as (check one): | _____ myself; _____ guardian of above named |         |  |     |
| Signature:              |   |         |  |     |
| Street Address:         |   |         |  |     |
| City, State, Zip:       |   |         |  |     |
| Phone:                  |   | E-mail: |  |     |

|                   |  |                    |  |  |
|-------------------|--|--------------------|--|--|
| Witness Name:     |  | Witness Signature: |  |  |
| Signature:        |  |                    |  |  |
| Street Address:   |  |                    |  |  |
| City, State, Zip: |  |                    |  |  |
| Phone:            |  | E-mail:            |  |  |