Attachment 1

DHS
Oregon Department of Human Services
Addictions and Mental Health Division

OREGON STATE HOSPITAL
Audio-Visual Authorization Permit

Date: _____ Name: _____ Unit: _____

I, _____, Unit _____

consent to and authorize _____

to take _____ of me/my legal charge, on _____
(photographs, videotape, etc.)

I understand that the purpose of which this will be used is as follow[illegible]

- ☐ Photograph for family or friends outside OSH that inclu[illegible]e clients.
- ☐ Group photograph that includes multiple clients to [illegible]d in treatment areas.
- ☐ OSH archive and history files.
- ☐ Public viewing or reading of information i[illegible]rticles or documentaries.
- ☐ Other (specify): _____

Patient authorization

Signature: _____ _____ Date: _____

Signature: _____ _____ Date: _____
(Guardian)

Witness: _____ _____ Date: _____

Program director/dis[illegible]pline chief: _____ Date: _____

CONFIDENTIAL: This information has been disclosed to you from records where confidentiality is protected by State Law (ORS 179.505) and Federal Law (45CFR, Part 164). You are prohibited from making further disclosure without specific written consent of the person or as otherwise permitted by law.

File: Informed consent
Thin: Six months
Form #: OSH-STK 75068 MR2 08/2010

ADDRESSOGRAPH