Media Release Form

Name of Individual: _____

Agency Name: _____ Program: _____

Birthday: _____ Phone Number: _____

Address:_____

City: _____ State:_____ Zip code: _____

I hereby grant members of the Eastern Region Alliance (ERA), including the St. Louis Office for Developmental Disability Resources, The Productive Living Board of St. Louis County, Developmental Disability Advocates of Jefferson County, and The Developmental Disabilities Resource Board of St. Charles County permission to use the above individual's name and photograph and any informational stories about their participation in the program(s) listed above. My authorization to use or disclose this information extends to persons working on behalf of the ERA to create or maintain materials in any format that may include the individual's information, photo, testimonial, video clip, or comment, including but not limited to printed materials, websites, and social media.

I understand and agree to the following:

1. Unless otherwise noted below, this authorization is giving permission to the four organizations in the Eastern Region Alliance (ERA), including the St. Louis Office for Developmental Disability Resources, The Productive Living Board of St. Louis County, the Developmental Disability Advocates of Jefferson County, and The Developmental Disabilities Resource Board of St. Charles County. **Please note any organizations that do NOT have permission here:** _____.
2. This authorization is valid for ten (10) years from the date of signing. I have the right to revoke this authorization at any time by providing written notice to any of the organizations in the ERA. Revoking this authorization does not apply to information already used or disclosed as permitted by this authorization before the written notice of revocation.
3. Signing this release is voluntary. Treatment, payment, enrollment, or eligibility for benefits cannot be conditioned upon signing this authorization.
4. Information disclosed as permitted by this authorization may be re-disclosed by recipients and is no longer protected by federal health information privacy law.
5. I have the right to request and receive a copy of this authorization.
6. I will not receive any payment or financial compensation for the information authorized for use and disclosure.
7. I waive the right to inspect or approve the finished product, including written or electronic copy, wherein the above individual's likeness appears.

Consent

I hereby certify that I am 18 years of age or older and my own legal guardian. I have read this release before signing below, and I fully understand the contents, meaning, and impact of this release.

_____ _____

Signature Date

_____

Printed Name

If the individual is under 18 years of age or has a legal guardian, the legal guardian must sign.

I hereby certify that I am the legal guardian of _____ and do hereby give my consent without reservation to the foregoing on behalf of this person.

_____ _____

Parents/Guardian's Signature Date

_____

Parent/Guardian's Printed Name