# AUTHORIZATION FOR RELEASE OF INFORMATION, PHOTOGRAPHS OR RECORDINGS FOR COMMUNICATION OR MEDIA-RELATION PURPOSES

**DS 6017** (Rev. 09/2024)

## INSTRUCTIONS:

This authorization must be completed and signed by a consumer, or his or her personal representative when the Department of Developmental Services' ("Department") or its agents and affiliates use or disclose photographs, recordings, or any other personal identifiable information of a consumer for communication or media-relation purposes. The consumer or his/her personal representative understand that this authorization is voluntary and not necessary to the consumer's enrollment in services, eligibility, payment (if applicable), treatment or care.

For an adult consumer a "personal representative" may be a conservator (if applicable) or other person with legal authority over the consumer's health care decisions. For a minor consumer, a "personal representative" is a parent, legal guardian or other caretaker with legal authority over the consumer's health care decisions. The terms "photograph," "recording" or "record" shall mean any audio or motion picture or still photograph in any format including, but not limited to, digital, audiotape, videotape, CD/DVD, or any other mechanical or electronic means of recording or reproducing images.

## AUTHORIZATION FOR USE AND DISCLOSURE

As set forth in detail below, I [*print name of consumer/personal representative*] _____, hereby authorize the use of [*print consumer name*] _____, [*print consumer's date of birth*]_____, photographs, recordings, and/or personal identifiable information for the Department's communication or media-relation activities without compensation.

### Who will disclose the information:

The Department and/or its agents and affiliates? Identifiable information, photographs, and recordings, that are disclosed or used for a Department communication or media-relations activity will be obtained from only you or those involved with your care and treatment.

### Other agents/affiliates:

### Who will use or receive this information:

Your information will be received by a communications representative from the Department or the following other individual/s:

The specified identifiable information, photographs or recordings in this authorization will be published in one or more of the following outlets and available to the public (please check all that apply):

- ☐ Education Publication / Videos/YouTube Channel
- ☐ Electronic Publishing (e.g., public website-www.dds.ca.gov)
- ☐ Social Media (e.g., Facebook/Twitter/Instagram)
- ☐ Promotion / Advertising
- ☐ Local / Regional / National News Outlet
- ☐ Other (please describe): _____

**The type of information to be used or disclosed:**
Identifiable health and personal information about you, photographs, and/or recordings relating to your care and treatment within the context of a Department communication or media relations activities.

**The following information can be used or disclosed (please be specific):**

**The purpose for the use or disclosure:**
Your information described above may be used for the following Department communication or media-relations activity/ies:

**When this authorization expires:**
This authorization expires at the termination or the specific communications or media-relations activity in which you have agreed to participate, or by **June 30, 2030**, whichever is longer.

After the expiration of this authorization, no further use or disclosure of your information, photographs or recordings will be made by the Department, unless authorization for such additional use or disclosure has been expressly provided by you or your personal representative. *Please be advised that following a Department communications or media-relations activity, your information, photographs, or recordings may be picked up and then reprinted or rebroadcast and disclosed to other people, entities and/or media outlets who are not connected to the Department.*

**How you can revoke this authorization:**

You can revoke this authorization at any time. Prior to any release of information, you have the right to modify or revoke this Authorization (change your mind and not allow information to be released), unless:

1) DDS has already provided records in reliance on the authorization; or
2) This authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

When you revoke authorization, the Department will not permit further release of your information identified in this authorization. Please understand that the Department may not be able to call back any photographs, recordings or other identifiable information already released. You may submit any revocations by email to the DDS Privacy Officer at PrivacyOfficer@dds.ca.gov or mail to:

Department of Developmental Services
ATTN: Office of Legal Affairs, DDS Privacy Officer
1215 O Street, MS 9-30
Sacramento, California 95814
(916) 654-1716 Fax

**Acknowledgement of Rights:**

By signing this authorization for, I understand and acknowledge the following rights:

1) The Department or its agents and affiliates may use or disclose the information specified and described herein, for the purposes described herein.
2) I may refuse signing this authorization to use or disclose my photographs, records or other identifiable information described herein.
3) Execution of this authorization is not conditioned upon my enrollment in services, eligibility, payment (if applicable), care, or treatment.
4) This authorization will remain in effect pursuant to the foregoing expiration date.
5) I understand that I may revoke this authorization at any time, provided I make the request for revocation in writing to the Department's Privacy Officer. I further understand that my request for revocation will be honored except to the extent that the Department has already taken action in reliance on this authorization and cannot cancel publication or recall distribution.
6) I understand that any photographs, recordings, or information used or disclosed may be subject to redisclosure by the recipient and therefore not subject to the protection of state and federal privacy laws. This includes redistribution through electronic media.
7) I understand that I have a right and will receive a copy of this form after it is completed and signed.

I have read this form and fully understand the content of this authorization. By signing below, I acknowledge that I have read and accept all the above terms.

**CONSUMER**
If the consumer is under the age of 18 years-old, a signature by the Parent, Legal Guardian or Conservator is required.

**Print Name:** _____

**Address:** _____

**Signature:** **Date:**

_____

**PERSONAL REPRESENTATIVE**
I declare that I am the parent or legal guardian of the minor child, or I am the personal representative, or the appointed conservator of the adult consumer named above, and I have the legal right to provide this authorization on the consumer's behalf.

**Print Name:** _____

**Address:** _____

**Signature:** **Date:**

**IF AUTHORIZATION WAS TRANSLATED**

**Print Name:** _____

**Language:** _____

**Signature:** **Time:** **Date:**

| Confidential Client Information<br>See Welfare & Institutions Code Sections 4514-4518; 5328; Civil Code section 56, et seq.; Government Code Section 6254; and 45 C. F. R. Parts 160 and 164 | ~ This Space for Department Use Only ~<br>*COPIES OF ALL SIGNED FORMS SHOULD BE DELIVERED TO THE DEPARTMENT PRIVACY OFFICER AND REMAIN ON FILE FOR THE DURATION OF THE COMMUNICATION OR MEDIA-RELATION ACTIVITY.* |
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| Date | Description of Change | Reviewer |
|---|---|---|
| 08/29/2024 | Office of Legal Affairs – Authorization expiration date update | Privacy Officer |