DEPARTMENT OF HEALTH SERVICES
Division of Care and Treatment Services
F-22538 (09/2016)

STATE OF WISCONSIN
Wisconsin Statutes
§ 51.61 (1) (o)
Administrative Rule
DHS 94.18

CONSENT TO FILM OR RECORD

Patient Name (Last, First MI)	ID Number	

By my signature below, I authorize the filming / recording as listed; and I understand that I may view the photograph or film or hear recording prior to any release. This consent may be revoked at any time by giving written notification to the facility / institution director.

Type of Filming / Recording	Date – Consent Expires
Video & Audio	**Until revoked in writing**

Name – Individual / Group Doing the Filming / Recording

The Caring Tree Children's Counseling Center

Purpose / Reason for Filming / Recording	Resulting Materials Can Be Used By
Video security cameras are used for the safety of our clients and staff.	**The Caring Tree** **Local authorities**

I further understand that I may specify periods during which or situation in which client / patient may not be filmed or recorded. I understand that neither last names nor other identifying information will be used or made available.

Filming / Recording Limitation – Times / Situations

Recording is limited to the common areas of the clinic.

SIGNATURE – Patient – If Presumed Competent		Date Signed
SIGNATURE – Parent for Child (Minor) or Guardian	Relationship	Date Signed

DISTRIBUTION: Original—Patient Record