ANCHORAGE COMMUNITY MENTAL HEALTH SERVICES, INC.
FAIRBANKS COMMUNITY MENTAL HEALTH SERVICES LLC

Authorization to Release Information for Publication, Marketing or Advocacy Purposes

Name: ____ DOB: _______________ (optional)
(Name of participant whose information is being released)

As a volunteer at **Alaska Seeds of Change, Alaska Youth Advocates, Fairbanks Community Mental Health Services and/or Anchorage Community Mental Health Services,** I hereby authorize **Anchorage Community Mental Health Services, Inc. and its wholly-owned subsidiaries ("the Organization")** to release images (likeness), art work, poetry, essay, transcribed recordings, descriptions, quotes, etc. in publications, advocacy, or marketing pieces produced by the agency, or at events sponsored by the Organization.

In giving my consent, I hereby release and hold harmless the Organization, their offices, employees, and designees from any and all responsibility or liability. I need not sign this form in order to ensure treatment, payment, enrollment, or eligibility for benefits.

I understand that my image and words may be used in publications that refer to general programmatic activities at AKSOC/AYA/FCMHS/ACMHS, including references to the provision of mental health services. I understand that I will be asked verbally if I wish to participate on each occasion when photographs or interviews are requested, and that I have the right to refuse with no repercussions.

I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the my volunteer manager, who will forward to the Community Relations and Clinical Records departments. I understand that the revocation will not apply to information that has already been released in reliance upon it. Furthermore, I understand that any Protected Health Information, once released into the public under this authorization, is no longer protected by the Organization's privacy practices. This authorization will expire when my employment or internship with ACMHS ends, or on ________________________________, unless otherwise revoked.

I understand that I may obtain a copy of the information to be used or disclosed as provided in 45 CFR 164.

_____ (initial) I understand that this will be used for the general purpose of raising awareness of programs at ACMHS **OR**
______(initial) I grant this permission for single-use use only for _________________________________.

For any questions regarding the specific use of this form please direct them to Jessica Cochran, Director of Community Relations and Communications.

How would you like your name displayed as the contributor? _____________________________________

(First and Last Name, First Name and Last Initial, Initials Only, Other, Anonymous)

____ _____________________________
Participant Signature Date

____ _____________________________
Parent or Guardian or Authorized Representative if under 18 Date