

# MEDIA

## Consent Form



I .....  
Name of person giving consent & parent/guardian if under 18 years of age

Hereby consent to the collection and use of my personal images by photography or video recording and words sourced through interview or survey.

I acknowledge these may be used on Bairnsdale Regional Health Service's website, in organisational documents, in newsletters, marketing and promotional materials, and publications that may or could be distributed widely.

Also understand that my consent can be withdrawn at any time, for future publications, in writing to the Office of the CEO at Bairnsdale Regional Health Service, PO Box 474 BAIRNSDALE VIC 3875

I give this consent voluntarily.

_____ Signature of person giving consent  / /	_____ Signature of parent/guardian < 18  / /
_____ Date	_____ Date
_____ Witness signature  / /	_____ Witness name (print)
_____ Date	