**Authorization to Disclose Information for Marketing and Related Purposes**

Subject:

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Phone |  |
| Address |  | City, State, Zip |  |
| Email Address |  | | |

I am authorizing the use or disclosure, as described below, of my photo by ILOTA for the purpose of the ILOTA website, social media, and/or Communique.

**Voluntary Authorization and Revocation:**

I understand that this authorization is voluntary and that I have a right to revoke this authorization at any time. I can do so by submitting my revocation in writing to the address listed above. I understand that my revocation will not apply to information that has already been released in response to this authorization. I understand that if I refuse to authorize the disclosure of information, the information may not be released.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of subject Date

For individuals unable to sign for themselves:

Signature of Authorized Representative (if applicable) Date

Person photographed is: ☐ a Minor ☐ Incompetent ☐ Deceased

I am: ☐ Legal Guardian ☐ Next of Kin of Deceased ☐ Executor of Estate

Person submitting picture:

I am a:

☐Clinician/Student ☐Family member ☐Client ☐Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of person submitting photo Date

If signed by other than ILOTA member, indicate relationship or authority: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_