MACOMB COUNTY COMMUNITY MENTAL HEALTH

Permission to Allow Fingerprinting, Audio Recording, Video Recording, Photographing, or One-Way Glass Viewing

I (legal guardian / parent of consumer) give permission for _____
Name of Provider

to: fingerprint; photograph; record; view through one-way glass (specify) _____
Name of Consumer

I understand that one-way glass viewing, fingerprints, photographs, and recordings will be used for the following purposes(s) only:

YES	NO	PURPOSE
[ ]	[ ]	To assist the MCCMH network provider professional staff in providing clinical supervision and / or treatment.
[ ]	[ ]	To assist the MCCMH network provider in conducting in-service training and education for staff, volunteers, or students, or for public relations materials.
[ ]	[ ]	To assist the MCCMH network provider to determine the name of the consumer (i.e. for identification purposes.)
[ ]	[ ]	To assist organizations other than Macomb County Community Mental Health network providers in providing clinical supervision, treatment, training or education to staff, or in promoting education and awareness to the community (e.g., in order to fight stigma).

Please check one:

- o I (legal guardian / parent of consumer) consent to having my first name and first initial only of my last name used in this project.
- o I (legal guardian / parent of consumer) consent to having my full name used in this project.

Any questions I have about this permission form have been explained to my satisfaction. I understand that I may freely withdraw this permission at any time. I understand that this consent may jeopardize my right to confidentiality as I may be identified as a recipient of services provided by a Macomb County Community Mental Health provider. This permission ends on the following date (not to exceed 12 months): _____ /____ _/_____ and/or condition, if applicable. (See below.)

Condition: _____

_____ _____
Witness Signature Date Recipient Signature Date

_____
Parent / Guardian Signature (if applicable) Relationship Date