I hereby give permission for Connecticut Valley Hospital to exhibit my artwork.

Location: CVH Campus or Artwork Events approved by CVH/DMHAS

Date(s): Artwork Exhibits as scheduled or Artwork Displays in various locations throughout the Campus (example: Page Hall Treatment Center)

I also give permission for my name to be displayed with the artwork.

This will be done by either:
- A label identifying the artwork, materials and my name, or
- Displayed if identified on the artwork (only if artist has signed his/her name to the artwork).

I hereby authorize Connecticut Valley Hospital to photograph/videotape me under the above described events. I understand that these photographs and/or videotape recordings may be:
- viewed by other patients and staff,
- posted on the units as a photo documentary in memorial of the above described events,
- used for Education/Training/Recovery Opportunities, however,
- will not be released outside of CVH or used for any other purpose without written authorization of the patient(s) in the photograph/video tape recording.

Event or condition upon which this authorization expires or date: ____________________________________________
(If blank, authorization will expire 12 months from date of signature below.)

Signature of Patient (or Legal Representative): ___________________________ Date: ________________

Witness Signature ___________________________ Witness Printed Name ___________________________

CANCELLATION/REVOCATION: ___________________________ Date ___________________________

File in Legal/Fiscal Section of the Medical Record