University of Massachusetts Medical School
UMASS

CONSENT TO OBTAIN AND PUBLISH PERSONAL INFORMATION

I hereby give my consent to the University of Massachusetts Medical School ("UMMS") and/or the Massachusetts Department of Children and Families ("DCF") to obtain and publish personal identifying information about [please circle to indicate] (me) (my minor child/ren) (me and my minor child/ren) by means of:

Please check as applicable:

- □ Quotation
- □ Reference
- □ Photograph
- □ Videotape
- □ Other (e.g., audio tape) please describe: _____

I understand that DCF is the agency that oversees the Family Resource Center Network ("FRC") and that publication of this personal information will be used as part of a project being conducted by UMMS for DCF.

I understand that such information and images become the property of UMMS and that they may be used as deemed appropriate by UMMS in such forms as photographs, slides, movies or videotapes, and/or published in printed materials, presentations, and publications, video displays, social media or on website pages created by UMMS. I understand that no fees will be paid to me for the use of such information and/or images.

I understand that this consent is voluntary. I also understand that, once disclosed, UMMS no longer has control over the identifying information and images and that there is potential for unauthorized re-disclosure. I release UMMS and its employees and agents from liabilities that may arise from the publication of such information and images.

_____ _____
Signature of Individual Date
(If minor child, signature of legal guardian)

Please print name: _____

_____
(Please print name of minor child here)

_____ _____
Signature of UMMS Witness Date
Please print name: _____