SOUTH CAROLINA DEPARTMENT OF
Behavioral Health and
Developmental Disabilities

AUTHORIZATION FOR PUBLICITY PURPOSES
Suicide Prevention Program

I am giving the South Carolina Department of Behavioral Health and Developmental Disabilities (BHDD) permission to publish my photo and/or comments in any or all of the following of the BHDD: in-house newsletters, intra and internet websites, social media accounts, use by centers, hospitals, mental health advocacy projects, general public presentations, informational materials, and televised or web-based public service announcements.

I give the South Carolina Department of Behavioral Health and Developmental Disabilities permission to use **(choose one and please print):**

My full name: _____

My first name _____

My pseudonym, pen name, or initials (how you want your name to appear if not your full name):

_____

Name of Publicity Activity: BHDD Suicide Prevention Month Campaign 2026

	I understand that my picture/image, name, voice, and/or testimonial/story may appear in this publicity activity.
☐	I understand that I may be recognized by family members, friends, employers, and the general community at large.
☐	I understand this authorization is irrevocable – that is, it cannot be changed or reversed.
☐	By agreeing to participate in this project, I agree to hold the BHDD harmless from claims related to any present or future use of my name, voice, image, photograph, likeness, and/or biographical information in connection with this project or any future showings/broadcasts/publications of this project.
☐	I also understand that applicable law may permit or require the use, disclosure or re-disclosure of information about me without my authorization.
☐	If I am a patient, I understand that I can refuse to sign this form and refuse to participate in or attend any publicity activity without jeopardizing my care and treatment by the BHDD.
☐	I fully understand the above statements and agree to participate in the above-mentioned publicity activity.
☐	I have been given a copy of this authorization.

PLEASE PRINT

Name: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Signature of participant (or guardian if participant is a minor): _____

Witness: _____ **Date:** _____