**RELEASE TO BE PHOTOGRAPHED AND/OR VIDEO RECORDED  
(for Narrators)**

Please check ONE of the following:

\_\_\_\_\_ I give permission to The Schizophrenia Oral History Project to use my photographic likeness in connection with my oral history in all forms and media for advertising, trade, and any other lawful purposes.  
  
\_\_\_\_\_ I give permission to The Schizophrenia Oral History Project to video record my interview and to use that video recording in connection with my oral history in all forms and media for advertising, trade, and any other lawful purposes.

\_\_\_\_\_ Although I have already agreed to provide my oral history to The Schizophrenia Oral History Project, at this time I decline to be photographed or video recorded in connection with the project. I prefer for my oral history to only be audio recorded.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subject Date

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subject Date

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Investigator Date

*Note: All signed forms will be kept in locked files in a locked office of one of the researchers.*