**Consent form for photography/filming**

I have read and understand the conditions and consent to my images being used as described.

|  |  |
| --- | --- |
| Please check☑ and fill out of the form. | |
| ☐ | I consent to (organization name) or Sasakawa Health Foundation using photographs and/or video recordings including images of me both internally and externally. |
| ☐ | I understand these images could be used in print and digital publications including websites, posters, movies, and social media. |
| ☐ | I understand my right to request corrections or deletions of the images and the information at any time, in which case they will not be used in future publications but may continue to appear in publications already in circulation. |
| Print Name |  |
| Signature |  |
| Date |  |

**Contact details**

Organization name

Contact person

Email:

(Tel: )

Sasakawa Leprosy (Hansen’s Disease) Initiative

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