



Minnesota Department of **Human Services** _____

Consent/Authorization for Release of Information

To be completed by the person giving consent/authorization (please print):

This information is being requested solely to verify the identity of the person giving consent/authorization.

NAME: _____ DATE OF BIRTH: _____

MAIDEN NAME OR ALIASES: _____

CURRENT ADDRESS: _____

CITY, STATE, ZIP _____

PREVIOUS OUT OF STATE ADDRESS: _____

CITY, STATE, ZIP: _____

SOCIAL SECURITY # _____ (Optional)

Authorization/Consent: I authorize the _____ (name of state) Child Abuse and Neglect Registry to release **all records regarding substantiated reports of maltreatment involving physical abuse or neglect of minors, in which I am named as the person found responsible for maltreatment, as required by Minnesota Law.**

The information will be released to: Minnesota Department of Human Services, Background Studies Unit, PO Box 64242, St. Paul, MN 55164-0242, (Fax #: 651-297-1490)

This information is being requested as part of a background study initiated by a county social service agency or private child placing agency to determine eligibility for child foster care licensure and/or adoptive placement.

Consequences: I know that state and federal privacy laws protect my records. I know:

- Why I am being asked to release this information;
- I do not have to consent to the release if this information, however if I do not consent, my background study will not be completed;
- The Minnesota Department of Human Services may be able to pass along my information to the county or private agency that initiated my background study;
- I may stop this consent with a written notice at any time, but this written notice will not affect information the agency has already released;
- This consent will end one year from the date I sign it, unless the law allows for a longer period.

Background Study Subject's Signature

Parent/Guardian Signature (Subject is a minor)

Date: _____

Date: _____

Updated: 03-24-08