

**DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES  
DIVISION OF PUBLIC WELFARE  
BUREAU OF SOCIAL SERVICES ADMINISTRATION**

**CONSENT FOR DISCLOSURE OF CLIENT INFORMATION**

This information is to be released from records whose confidentiality is protected by Federal law regarding right to privacy, which prohibits you from making any further disclosure of this information without the specific written consent of the person to who it pertains, or as otherwise permitted by such regulations. A General Authorization for the release of medical or other information will not be sufficient for this purpose.

Name of program to give information: Department of Public Health & Social Services, Child Protective Services

Name of person or organization to receive information: Department of Public Health & Social Services, Home Evaluation and Placement Services Section

Name of client (PRINT NAME): \_\_\_\_\_

Purpose or need for the disclosure (please be very specific): To verify if any referrals of child abuse/neglect were made on the above named individual.

Extent or nature of information to be disclosed (please be very specific): Type of referral and outcome of investigation.

This Consent for Disclosure of Client Information may be revoked by the client at any time.

This Consent for Disclosure of Client Information shall have a duration not to exceed (90) days for the purpose for which it is given.

\_\_\_\_\_  
Signature of Client/Guardian/Parent

**CINDY L. CHUGRAD**  
\_\_\_\_\_  
Signature of Person Requesting Information

Date: \_\_\_\_\_

Date: \_\_\_\_\_

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I HEREBY REVOKE CONSENT FOR DISCLOSURE OF THE INFORMATION TO THE PERSON OR ORGANIZATION ABOVE AS OF:

\_\_\_\_\_  
Signature of Client/Guardian/Parent

\_\_\_\_\_  
Date: