



Minnesota Department of **Human Services**
Consent/Authorization for Release of Information from Minnesota Child Abuse and Neglect Registry
Related to Child Foster Care or Adoption Study

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(s): _____
(include any other names by which you have been known)

DATE OF BIRTH: _____ SS#(optional) _____

CURRENT ADDRESS: _____ CITY, STATE, ZIP _____

MINNESOTA ADDRESS(ES): _____
(City, State, Zip for each)

Authorization/Consent: I authorize the Minnesota Department of Human Services 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.

The information will be released to:

NAME: _____ AGENCY: _____

ADDRESS: _____ CITY, STATE, ZIP _____

PHONE #: _____ Fax #: _____

This information will be used for: _____

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 of this information;
- That, generally, I must give my written consent for the Minnesota Department of Human Services to give out the information;
- The person or agency who gets my information may be able to pass it on to others;
- If I do not consent, the information will not be released unless the law otherwise allows it;
- 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.

Individuals' Signature _____ Date: _____

Parent/guardian/authorized representative (If individual is a minor) _____ Date: _____

Please include a check or money order in the amount of \$20.00 payable to the Minnesota Department of Human Services for each check requested. Return completed form and payment to:
Minnesota Department of Human Services – Licensing Division
Background Studies Unit
PO Box 64242
St. Paul, MN 55164-0242