

**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION
ADULT PROTECTIVE SERVICES**

Last Name			First	Middle	Date of Birth
Maiden Name or Other Names Known By					Social Security Number

I (we) _____ authorize the following information to be disclosed
as indicated below:

Information to be released FROM: ___ The Department for Children and Families (DCF) ___ School District USD #: _____ ___ Medical practitioner, clinic, center or facility: _____ ___ Mental health practitioner, clinic, center or facility: _____ ___ Social Service agency or provider: _____ ___ Attorney/Law Enforcement ___ Financial Institutions ___ Other _____	Information to be released TO: ___ The Department for Children and Families (DCF) ___ School District USD #: _____ ___ Medical practitioner, clinic, center or facility: _____ ___ Mental health practitioner, clinic, center or facility: _____ ___ Social Service agency or provider: _____ ___ Attorney/Law Enforcement ___ Financial Institutions ___ Other _____
Information to be released: _____ _____ _____ _____ _____	
The purpose or reason for the release is to facilitate a thorough Adult Protection Service investigation and/or coordinate community resources as appropriate: _____ _____ _____ _____	
Read before signing: I understand that the information which I have authorized to be disclosed will be used for the purpose(s) stated. I acknowledge that it is my responsibility to be aware of any rights of confidentiality which I may have regarding the information which I am releasing and that by signing this consent I am waiving my rights, if any, to confidentiality for purposes which I have approved. I understand that my records are protected, and cannot be disclosed without my written consent unless otherwise provided in K.S.A. 39-1434(b). This consent may be revoked in writing at any time prior to any action which has been taken in reliance upon it. This consent will expire within 120 days unless otherwise provided.	

Date

Signature of Consenting Party

Witness (If Person Unable to Sign)

Expiration Date (Prior to 120 days)

Signature of Parent, Guardian or Authorized Representative
When Required



Department for Children
and Families
*Prevention and
Protection Services*

Strong Families Make a Strong Kansas