



CHILDREN'S ADMINISTRATION
AUTHORIZATION TO RELEASE INFORMATION TO THE COURT
(PER RCW 13.50.100)

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|---|--------------------------------|---|--------------------------------------|
| AUTHORIZATION TO DISCLOSE RECORDS OF: | | | |
| NAME LAST | FIRST | MIDDLE | DATE OF BIRTH |
| The following information may help in locating records: | | FORMER NAMES | |
| CLIENT IDENTIFICATION NUMBER | OTHER IDENTIFICATION NUMBER | DATES OF SERVICE | LOCATION OF SERVICE |
| DISCLOSE TO: | | | |
| NAME LAST | FIRST | MIDDLE | TITLE |
| ORGANIZATION OR BUSINESS NAME IF APPLICABLE | | | |
| ADDRESS | | CITY | STATE ZIP CODE |
| TELEPHONE NUMBER (INCLUDE AREA CODE) | FAX NUMBER (INCLUDE AREA CODE) | E-MAIL ADDRESS | |
| REASON FOR DISCLOSURE | | | |
| AUTHORIZATION: | | | |
| I authorize Children's Administration to release information from my records. I understand that information may be provided verbally or by computer data transfer, mail, fax or hand delivery. I understand this authorization allows the court to review the information and that it may be shared with other parties to the court action. | | | |
| I authorize the release of information regarding any "founded" CPS reports in which I am named as a subject since October 1, 1998, as well as information regarding any pending CPS investigations in which I am named as a subject. | | | |
| ?? This permission is valid for <input type="checkbox"/> 90 days or <input type="checkbox"/> until _____ (date or event). ?? I may revoke or withdraw my permission in writing at any time, but that will not affect information already disclosed. ?? I understand that my records may no longer be protected under the laws that apply to DSHS after this disclosure. ?? A copy of this form is valid to give my permission to disclose records. | | | |
| AUTHORIZED BY (SIGNATURE) | | DATE SIGNED | TELEPHONE NUMBER (INCLUDE AREA CODE) |
| PRINT NAME | | WITNESS/NOTARY (SIGN AND PRINT NAME, IF APPLICABLE) | |
| If I am not the person who is the subject of the records, I am authorized to sign because I am the: (attach proof of authority) <input type="checkbox"/> Parent of minor <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Personal Representative <input type="checkbox"/> Other: | | | |

Notice to those receiving information: If these records contain information about HIV, STDs, or alcohol or drug abuse, you may not further disclose that information under federal and state law without specific permission of the subject and meeting specific legal requirements.