

Authorization and Consent to Share Records (Child Placing Agency/Group Care Staff)

Authorization and Consent to Share the Records and Information of:	
NAME	DATE OF BIRTH
PROVIDER NUMBER OF AGENCY (IF KNOWN)	
Consent:	
<p>I consent and authorize the Department of Children, Youth and Families (DCYF) Licensing Division (LD) to share records related to child welfare and character and suitability with <i>(name of Agency/Facility)</i> for the purpose of assessing me for access to children in out of home care. Information may be shared verbally or by computer data transfer, mail, or hand delivery.</p>	
Waiver of Confidentiality for Background Check:	
<p>I understand that I may have a right to the confidentiality of some information gathered or obtained by DCYF, in connection with the aforementioned agency. Information may include criminal history, Department of Social and Health Services (DSHS), and DCYF records. I understand that DCYF is not authorized to release confidential information about me unless permitted by me or by law.</p> <p>Specific information to be released: The outcome of the State Patrol and FBI background checks, as well as FamLink/DCYF Information System which relates to my suitability to have unsupervised and/or supervised access to children in out-of-home care.</p> <p>Understanding that I have a right to confidentiality, I hereby waive that right in order to permit the aforementioned agency to have access to all information as listed above. I authorize LD to use my confidential information and disclose it to the aforementioned agency to assess my suitability for access to children in out-of-home care.</p>	
Statement of Understanding:	
<ul style="list-style-type: none"> ● I understand this consent is valid for as long as DCYF LD and the Agency/Facility need records for the purpose of assessing me for access to children in out-of-home care. ● I understand I may revoke/withdraw this consent at any time in writing, but that will not affect any information already shared. ● I understand records shared under this consent may no longer be protected under the laws that apply to DCYF and the Agency/Facility. ● I understand a copy of this form is valid to give my permission to share records. 	
Signatures	
SIGNATURE	DATE
PARENT OR OTHER REPRESENTATIVE NAME (IF APPLICABLE)	
PARENT OR OTHER REPRESENTATIVE SIGNATURE (IF APPLICABLE)	DATE
<p>If I am not the subject of the records, I am authorized to sign because I am the:</p> <p style="text-align: center;"> <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Personal representative <input type="checkbox"/> Other: </p>	