**DCYF - AUTHORIZATION FOR**

**RELEASE OF INFORMATION**

Name (First, Middle, Last) DOC number Date of birth

Last known address City State Zip code

|  |  |  |
| --- | --- | --- |
| **Child(ren) name** | **Date of birth** | **Gender** |
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Have you been involved with Child Protective Services or welfare in Washington or another state?

[ ]  Yes [ ]  No If yes, what state:       Approx. date:

Has any child been involved with Indian Child Welfare in Washington or another state?

[ ]  Yes [ ]  No If yes, what state:       Approx. date:

Have you been involved with Tribal Court or other tribal services in Washington or another state?

[ ]  Yes [ ]  No If yes, what state:       Approx. date:

**Give a brief description of the case:**

**Initial:**

 I allow any tribal and/or state child welfare/protection agency to disclose any level of information they may have on me, my family and/or children, including but not limited to founded (substantiated), unfounded (unsubstantiated), and “information only” referrals.

 I allow the Department of Children, Youth, and Families (DCYF) and/or Department of Corrections to re-disclose protected health and/or other information to mental health, substance use disorder, and child welfare service providers.

I certify under penalty of perjury that the information provided in the attached documents are true and accurate.

Signature Date

**The contents of this document may be eligible for public disclosure. Social Security Numbers are considered confidential information and will be redacted in the event of such a request. This form is governed by Executive Order 16-01, RCW 42.56, and RCW 40.14.**

Distribution: **ORIGINAL** - DCYF **COPY** - Case manager file