**Consent/Authorization for Release of Information from the Division of Child and Family Services**

**Related to the MIHOPE Study**

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| --- |
| **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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NEVADA ADDRESS(ES):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(City, State, Zip for each)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Authorization/Consent:** I authorize the Nevada Division of Child and Family Services to release all records it maintains regarding reports of maltreatment involving physical abuse or neglect of minors, including those in which I am named as the person found responsible for the minor.

**The information will be released to:**

NAME:\_\_MDRC\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGENCY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS:\_\_16 East 34th street\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY, STATE, ZIP\_\_New York, NY 10016\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE #:\_\_\_212-340-8863\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX #:\_\_\_212-532-8453\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This information will be used for:** \_The data will be used by the Mother and Infant Home Visiting Program Evaluation\_\_\_\_\_

**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 Nevada Division of Child and Family 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 at the end of the MIHOPE study.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Individual’s Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian/Authorized Representative (if individual is a minor)