DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF CHILD AND FAMILY SERVICES

Consent/Authorization for Release of Information from the Division of Child and Family Services Related to the MIHOPE Study

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)