



Treatment Foster Care Program

## Authorization for Release of Information and Records

I authorize for the agencies specified below to release any and all information regarding any referrals or contacts regarding the following: criminal history, child abuse and neglect, elderly abuse and neglect, adoption and foster care studies, or other information relating to foster care that they may possess about me.

This information is being released to:

Samaritan Counseling Center Treatment Foster Care, 1478 Kenwood Dr. Suite 1  
Menasha, WI 54952. Fax (920) 886-9357

- The \_\_\_\_\_ County, Department of Health and Human Services  
Your County
- The City of \_\_\_\_\_ Police Department  
Your City
- The Department of Justice Crime Information Bureau (CIB)
- Previous Foster Care Agency \_\_\_\_\_
- Previous Foster Care Agency \_\_\_\_\_

Purpose of disclosure: Part of the application/re-licensing process for becoming a Treatment Foster Parent

This authorization expires (90 days for written information and 1 year for ongoing communication) after this date: \_\_\_\_\_  
Today's Date

The information released to the agency specified above cannot be passed to any other agency without your authorization. I understand that I may revoke this authorization, in writing, at any time except where information has already been released as a result of this authorization. Unless revoked, this authorization will remain in effect until the expiration date indicated above.

I authorize copies of this form to be mailed/faxed to the agencies listed above.

Name (print) \_\_\_\_\_

Signature \_\_\_\_\_