



**CHILD FOSTER CARE OR ADOPTION BACKGROUND STUDY**

**Consent/Authorization for Release of Information from Minnesota State-wide Database for Substantiated Abuse and Neglect**

**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: \_\_\_\_\_

MINNESOTA ADDRESS(ES): \_\_\_\_\_  
(City, State, Zip for each)

**Authorization/Consent:** I authorize the Minnesota Department of Human Services to release all records regarding substantiated reports of maltreatment involving physical abuse or neglect of minors or vulnerable adults, in which I am named as the person responsible for maltreatment.

**The information will be released to:**

NAME: \_\_\_\_\_ AGENCY: NDDHS, Criminal Background Check Unit

ADDRESS: 600 E Boulevard Ave, Dept 325 CITY, STATE, ZIP: Bismarck, ND 58505-0250

PHONE #: 701-328-7575 FAX #: 701-328-0358

**This information will be used for:** \_\_\_\_\_

**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 Minnesota Department of Human 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 one year from the date I sign it, unless the law allows for a longer period.

\_\_\_\_\_  
Background Study Subject's Signature

Date: \_\_\_\_\_

\_\_\_\_\_  
Parent/guardian/authorized representative (If individual is a minor)

Date: \_\_\_\_\_

**There is a \$20 fee per check. Please include a check or money order payable to the Minnesota Department of Human Services. Return completed form and payment to: Minnesota Department of Human Services – Office of Inspector General/Background Studies Division – PO Box 64172 – St. Paul, MN 55164-0172.**