MISSOURI DEPARTMENT OF SOCIAL SERVICES
CHILDREN'S DIVISION

AUTHORIZATION FOR RELEASE OF NON-MEDICAL RECORDS BY/TO CHILDREN'S DIVISION

In signing this release, you are authorizing the Children's Division, or another person or organization with whom you are acquainted to release or obtain information regarding you or your family in the course of your involvement with the division. All parties involved should be aware that this release is for use with **NON-MEDICAL** records. **This release is not HIPAA-compliant and should not be used for any records containing health information protected by the Health Insurance Portability and Accountability Act (HIPAA).**

I, _____ **do hereby authorize and request the:**
(Name of Individual, Guardian, Legal or Personal Representative)

☐ Children's Division

☐ Family Support Division

☐ School _____
(Name of School)

_____
(Address of School)

☐ Other Party _____
(Specify from whom information is requested)

_____
(Address)

To release records pertaining to:

☐ _____ _____
(Name of Individual, Guardian, Legal or Personal Representative) (DOB)

☐ My Child(ren):

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
(Specify Name(s) of Children)	(DOB)	(Specify Name(s) of Children)	(DOB)

To:

☐ Children's Division

☐ Other Party _____
(Specify who will receive information requested)

I understand certain restrictions apply to release of this information, in accordance with state and federal laws. I understand I am not entitled to information regarding the identity of a reporter of abuse and neglect. I understand portions of the record to which I am not legally entitled will be redacted, in accordance with state and federal laws.

This authorization will expire on _____ or 90 days from the date of the signature below, if not specified.
(Specify Date)

In signing below and providing my social security number as a personal identifier, I am affirming that I am legally authorized to request this release of information.

_____ _____ _____
(Print Name) (Social Security Number) (DCN, if available)

_____ _____
(Signature) (Date)

Distribution: Original - Name of Individual, Guardian, Legal or Personal Representative Copy – Case File CD-98 REV12/09