

Authorization for Release of Information for DCF CPS Search



I, _____ do hereby authorize the Department of Children and Families to research
(Type Applicant Name)

their records for any and all information concerning charges, findings, dispositions, etc., relating to child abuse or neglect in which I/my family may have been named, and to release it to the agency listed below. I understand that this information will determine my suitability solely for (check one): Employment Day Care Volunteer Intern Mentor Other

By: Agency Name /
Address/City / State / Zip
Code

Attention: **Advanced Behavioral Health**
Agency: **ATTN: DCF Credentialing Dept. - S. Tkacs**
Address: **213 Court St., Middletown CT 06457** State: _____ Zip Code: _____
City: _____

I release the Department of Children and Families from any liability for any damages I may incur which may result from the release / use of this information. I submit my following information to assist the Dept. of Children and Families in their search.

PLEASE TYPE OR PRINT LEGIBLY / LEAVE NO BLANK SPACES

Name:	_____	_____	_____	Date of Birth:	_____
	Last	First	Middle	Social Security #:	_____
Address:	_____			How Long at Current Address:	_____
	Street (No P.O. Boxes)			Yrs.	Mos.

	City			State	Zip Code

Previous Address(es) List All for the Last Five Years (continue on reverse side of form if necessary)						<input type="checkbox"/> Check if reverse side used	
Street (No P.O. Boxes)	Apt. #	City/Town	State	Zip Code	Dates		
					From Month/Yr.	To Month/Yr.	

Other Names I have Used - Including Maiden, Previous Marriages(s)			<input type="checkbox"/> Check if reverse side used
Last	First	Middle	

Name of Spouses/Other Adults in the Home - Past and Present						<input type="checkbox"/> Check if reverse side used
Last	First	Middle	D.O.B. Month/Day/Year	Social Security #	Signature/Date (If Still in the Home)	

Names of ALL Child(ren) - Biological, Stepchildren Including Adult Children In or Out of the Home					<input type="checkbox"/> Check if reverse side used
Last	First	Middle	Sex	D.O.B. Month/Day/Year	

Date: _____ Applicant Signature: _____

THIS AUTHORIZATION WILL EXPIRE 180 DAYS AFTER THE DATE OF THE SIGNATURE
FORMS NOT FILLED OUT COMPLETELY AND PRINTED CLEARLY WILL BE RETURNED

DCF Conducts a Search of the CT Registry ONLY The Accuracy of this Search is Limited to the Information Provided by the Applicant to DCF

Mail to: **DCF Hotline Background Searches - 505 Hudson Street - 5th Floor - Hartford, CT 06106**

DCF-CT HOTLINE CPS-BGC USE ONLY DO NOT WRITE BELOW THIS LINE

DATE: _____ RECORD FOUND: YES _____ NO _____ Processor's Initials: _____