

AUTHORIZATION FOR RELEASE OF INFORMATION FROM DCF

A separate form must be completed by each employee of a childcare facility and each member of a family day care provider's home who is 16 years of age or older.

I, **(Your name)** _____, do hereby authorize the Department of Children and Families (DCF) to research their records for any and all information concerning charges, findings, dispositions, etc., relating to child abuse, neglect, substance abuse, education, HIV, psychological, psychiatric and any other medical information in which I, have been named, and to release this information in whole to the Department of Public Health (DPH). I further authorize the DPH to release any final DCF substantiations of abuse or neglect to the Director/Operator or other person in charge of a childcare facility for purposes of determining my suitability or the suitability of an adult who resides in my household to provide childcare services. I release DCF and the DPH from any liability for any damages I may incur, which may result from the release or use of this information. I submit the following information to assist DCF in their search and to assist DPH in the licensing decision. This release is valid throughout the term of the license or approval.

Type of Child Care Facility (Check One): FAMILY DAY CARE HOME CHILD DAY CARE CENTER GROUP DAY CARE HOME

Name of Provider/Facility: _____ **License #** _____

Address (No./Street/City/State/Zip): _____

YOUR INFORMATION: Name _____		Date Of Birth _____/_____/_____
<input type="checkbox"/> Male	<input type="checkbox"/> Female (Check One)	Telephone Number _____ Social Security Number _____ - _____ - _____
Other names you have used (maiden, married, etc.) _____ (Enter "N/A" for none)		
YOUR SIGNATURE: _____		CURRENT DATE: _____

YOUR RESIDENCE FOR THE LAST FIVE YEARS					
Number and Street	City	State	Zip Code	Years / Months	
1. PRESENT Address: _____				How long have you lived there? _____/_____/_____	
2. PREVIOUS Address: _____				How long did you live there? _____/_____/_____	
3. PREVIOUS Address: _____				How long did you live there? _____/_____/_____	
Continue on the reverse side of this form if necessary.					

CHILDREN WHO HAVE LIVED WITH YOU List all the children who have <u>ever</u> lived with you.						
Last Name	First Name	Date of Birth	Sex (Check One)	Social Security Number	Lives or lived with you (Check One)	
_____	_____	_____/_____/_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____-_____-_____	<input type="checkbox"/> Presently	<input type="checkbox"/> Previously
_____	_____	_____/_____/_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____-_____-_____	<input type="checkbox"/> Presently	<input type="checkbox"/> Previously
_____	_____	_____/_____/_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____-_____-_____	<input type="checkbox"/> Presently	<input type="checkbox"/> Previously
_____	_____	_____/_____/_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____-_____-_____	<input type="checkbox"/> Presently	<input type="checkbox"/> Previously
Continue on the reverse side of this form if necessary.						
_____/_____/_____						
SIGNATURES of parents whose children live with you. (Signature is required for children 16 yrs of age or older, presently living with you.)						

CHECK HERE IF USING REVERSE SIDE

<p>Return form to: Department of Public Health 410 Capitol Avenue, MS# 12LEG P.O. Box 340308 Hartford, CT 06134-0308</p> <p>Rev. 1/9/09</p>
