

STATE OF HAWAII / DEPARTMENT OF HUMAN SERVICES / SOCIAL SERVICES DIVISION

PROGRAMS: CHECK ONE ONLY:

(* ITS: Forward original results to CWS FHLU-See page 2, and mail copy to requesting agency)

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|--|--|---|
| <input type="checkbox"/> CCFH/CMA | <input type="checkbox"/> DOH-ADAD | <input type="checkbox"/> DHS-Med-QUEST (Other Than DOH- DDD) |
| <input type="checkbox"/> ACCS General | <input type="checkbox"/> DOH-AMHD | <input type="checkbox"/> DHS-Office of Youth Services (Other Than Safe House Staff) |
| <input type="checkbox"/> ACCS Out-of-State Request | <input type="checkbox"/> DOH-OHCA | <input type="checkbox"/> DHS-Office of Youth Services Safe House Staff (P)* |
| <input type="checkbox"/> Adult Day Care Center | <input type="checkbox"/> DOH-DDD | |
| <input type="checkbox"/> Foster Grandparent | <input type="checkbox"/> DOH-CAMHD (Other Than Ther.Hms/Staff) | |
| <input type="checkbox"/> Senior Companion | | |
| <input type="checkbox"/> Respite Companion | | |

AUTHORIZATION TO RELEASE INFORMATION FROM THE ADULT/CHILD PROTECTIVE SERVICES CENTRAL REGISTRY

REQUESTING INDIVIDUAL OR AGENCY: (Print or Type all information)

Name: _____ Phone: _____
 Address: _____ ATTN: _____

I hereby authorize the Department of Human Services (DHS) or its designee to conduct the following Protective Services Central Registry Check: **Adult Protective Services (APS)** and/or **Child Abuse and Neglect (CAN)** on me and to release the information to the requesting individual or agency as indicated above. * Program with an asterisk: mail copy of results to requesting individual or agency and forward original to CWS FHL Unit noted on the bottom of page 2.

Full name: _____ Date of Birth: _____
 Social Security Number: _____ Telephone Number: _____
 Any Alias(es)/Former Name, including Maiden Name: _____

Current Address: _____

The information to be released shall be limited to the history of abuse or neglect in which I was identified as a perpetrator and shall include date(s) of CONFIRMED incident(s) only and type of abuse for each incident.

I understand that the information I provide about me shall be used solely for the purpose of conducting the APS and/or CAN Protective Services Central Registry Check. I also understand that the release of this information may be used as part of a background check for employment, volunteer, licensure, or certification purposes which may result in suspension or termination.

This authorization is good until ____ / ____ / ____ or _____.
 Date Event

When no date or event is specified, the authorization shall expire one year from the date the authorization is signed.

Signature: _____ **Date:** _____

Mail or FAX the completed form to: Insights to Success, P. O. Box 1290, Honolulu, Hawaii 96807; or FAX: 532-8331. If you have questions, please call: OAHU: 532-8322 or Neighbor Islands: (877) 532-8322.

