

**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION
ADULT PROTECTIVE SERVICES**

Last Name	First	Middle	Date of Birth / / - -
Maiden Name or Other Names Known By			Social Security Number

I (we) _____ authorize the following information to
be disclosed as indicated below:

Information to be released FROM:	Information to be released TO:
The Department of Social and Rehabilitation Services (SRS)	The Department of Social and Rehabilitation Services (SRS)
School District USD #:	School District USD #:
Medical practitioner, clinic, center or facility:	Medical practitioner, clinic, center or facility:
Mental health practitioner, clinic center or facility	Mental health practitioner, clinic center or facility:
Social Service agency or provider:	Social Service agency or provider:
Attorney/Law Enforcement	Attorney/Law Enforcement
Financial Institutions	Financial Institutions
Other	Other

Information to be released:

The purpose or reason for the release is to facilitate a thorough Adult Protection Service investigation and/or coordinate community resources as appropriate:

Read before signing: I understand that the information which I have authorized to be disclosed will be used for the purpose(s) stated. I acknowledge that it is my responsibility to be aware of any rights of confidentiality which I may have regarding the information which I am releasing and that by signing this consent I am waiving my rights, if any, to confidentiality for purposes which I have approved. I understand that my records are protected, and cannot be disclosed without my written consent unless otherwise provided in K.S.A. 39-1434(b). This consent may be revoked in writing at any time prior to any action which has been taken in reliance upon it. This consent will expire within 120 days unless otherwise provided.

Date	Signature of Consenting Party
Witness (If Person Unable to Sign)	Expiration Date (Prior to 120 days)
	Signature of Parent, Guardian or Authorized Representative When Required