Washington State Department of CHILDREN, YOUTH & FAMILIES

LICENSING DIVISION (LD)

Authorization and Consent to Share Records Child Placing Agency (CPA) Home

Authorization and Consent to Share the Records and Information of:			
NAME			DATE OF BIRTH
ADDRESS	CITY	STATE **, WA**	ZIP CODE
TELEPHONE NUMBER	ASSOCIATED WITH PROVIDER NUMBER (IF KNOWN)		

Consent for Foster Home Licensing:

I consent to the Department of Children, Youth, and Families (DCYF) Licensing Division (LD) and Child Placing Agency (CPA) to obtain my confidential information. I authorize LD and the CPA to use my confidential information and disclose it to each other to assess my suitability for access to children in out-of-home care.

If I request to move my foster home license from my current certifying CPA to another CPA or LD, I authorize the exchange of information between LD and my current or future certifying CPA regarding my current or prior foster home records. I understand this information may be used to determine suitability for licensing with LD or certification with another CPA. Information may be shared verbally or by computer data transfer, mail, or hand delivery.

Waiver of Confidentiality for Background Check:

I understand that I may have a right to the confidentiality of some information gathered or obtained by DCYF, in connection with my foster home licensing with the aforementioned CPA. Information may include criminal history, Department of Social and Health Services (DSHS), and DCYF records. I understand that DCYF is not authorized to release confidential information about me unless permitted by me or by law.

Specific information to be released: The outcome of the State Patrol and FBI background checks, as well as FamLink/DCYF Information System which relates to my suitability to have unsupervised and/or supervised access to children in out-of-home care.

Understanding that I have a right to confidentiality, I hereby waive that right in order to permit the aforementioned CPA to have access to all information as listed above. I authorize LD and the CPA to use my confidential information and disclose it to each other to assess my suitability for access to children in out-of-home care.

Statement of Understanding:

- I understand this consent is valid for as long as DCYF LD and need records for the purpose of assessing me for access to children in out-of-home care.
- I understand I may revoke/withdraw this consent at any time in writing, but that will not affect any information already shared.
- I understand records shared under this consent may no longer be protected under the laws that apply to DCYF and .
- I understand a copy of this form is valid to give my permission to share records.

Signatures	
SIGNATURE	DATE
PARENT OR OTHER REPRESENTATIVE NAME (*IF APPLICABLE*)	
PARENT OR OTHER REPRESENTATIVE SIGNATURE *(IF APPLICABLE)*	DATE

If I am not the subject of the records, I am authorized to sign because I am the:

☐ Parent ☐ Legal Guardian ☐ Personal representative ☐ Other: