

# AUTHORIZATION FOR THE RELEASE OF CHILD ABUSE AND NEGLECT RECORDS

Pursuant to W. Va. Code §49-5-101, I authorize the Department of Health and Human Resources Bureau of Social Services to release to \_\_\_\_\_ copies of any and all child abuse and neglect records relating to services provided to:

**Name:**

**Date of Birth:**

**Social Security Number:**        **XXX-XX-\_\_\_\_\_**

I hereby affirm that I have the right, pursuant to applicable exemption found under W. Va. Code §49-5-101, to authorize the release of these records as I am the:

- Child
  
- Parent whose parental rights have not been terminated.
  
- Attorney of the child or parent

\_\_\_\_\_  
Initials

I understand that I have the right to revoke this authorization at any time except to the extent that action has been taken in reliance on it. I understand that if I revoke this authorization that I must do so in writing and present my written revocation to the General Counsel for Bureau for Social Services, 350 Capitol Street, Charleston, West Virginia 25301.

I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure. If I have questions about disclosure of this information, I can contact the West Virginia Department of Health and Human Resources Bureau of Social Services, phone number (304) 558-4194.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature