RELEASE OF INFORMATION - SEARCH/DISCLOSURE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CHILDREN AND FAMILY SERVICES-ADOPTIONS
SFN 1992 (1-2023)

Clear Fields

Name		Telephone Number	
Address	City	State	ZIP Code
Email Address	Agency		

In order for the licensed child placing agency or Department of Health and Human Services to release any identifying information about you, either at the time of adoptive placement or during a search process, it is necessary to have your permission. Please indicate how much information may be released by selecting from the following options:

CHECK APPROPRIATE BOX:

☐ 1. **I do not authorize** this agency to share any information about me.

☐ 2. The agency may share the following information about me. Information to be shared:

☐ 3. The agency may share identifying information about me, including my name, address, and telephone number.

Signature	Date
Maiden Name (if applicable)	

Indicate if you are:

☐ Adopted Individual ☐ Child of Deceased Adopted Individual ☐ Birth Parent ☐ Birth Sibling ☐ Adoptive Parent

Distribution: **ORIGINAL** - Child Placing Agency
COPY - Client, HHS