AUTHORIZATION TO RELEASE INFORMATION - CHILD SUPPORT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CHILD SUPPORT
SFN 1756 (6-2025)

*PRIVACY STATEMENT: Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification.

1. CUSTOMER INFORMATION

Name of Customer	Social Security Number*	Date of Birth	
Address	City	State	ZIP Code

2. PERSON OR ENTITY RECEIVING THE INFORMATION

I hereby authorize the Child Support Section of the North Dakota Department of Health and Human Services to release information to the person or entity listed below.

Name of Person or Entity to Receive Information			
Address	City	State	ZIP Code
3. The following information may be released (Be specific)			
4. The information identified above will be used for (Describe each purpose)			

5. This Authorization to Release Information remains in effect for one year from date signed unless a different expiration date is entered here (MM/DD/YYYY):

NOTICE: This authorization is voluntary. Eligibility for benefits or services is not conditioned on obtaining an authorization. This authorization remains in effect until the expiration date above, unless specifically revoked sooner by written notice to Child Support. Any information disclosed prior to Child Support's receipt of written notice of revocation shall not be a breach of confidentiality. A copy of this authorization is as effective as the original. Unless otherwise agreed in writing, information may be disclosed under this authorization in any form or method, including oral, written, or electronic transmission. Information disclosed to another entity may be subject to redisclosure by the recipient, in which case it may not be protected by state or federal law.

Signature of Customer	Date