



Child and Family Services

*An Office of the
Department of Health and Human Services*

Paul R. LePage, Governor

Mary C. Mayhew, Commissioner

Department of Health and Human Services
Child and Family Services
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TTY Users: Dial 711 (Maine Relay)

**AUTHORIZATION RELEASE OF CONFIDENTIAL SUBSTANTIATED
MAINE CHILD ABUSE AND NEGLECT RECORDS INFORMATION**

Agency/Provider to receive this information:

Agency ID#: 306

**Family Division
Administrative Office of the Courts
171 State House Station
Augusta, ME 04333**

I, _____, authorize the Maine Department of Health and Human Services to release
(Please print clearly)
confidential information to the above agency regarding whether I have been involved in a substantiated Maine
Child Protective Services case and the nature of that involvement.

I understand that:

- This release may be revoked by me in writing at any time, except for information that has already been released. For details contact Child Protective Intake at 1-800-452-1999 x2.
- Disclosure will include the determination by the Department of any specific abuse/neglect to a child by me and any actions taken by me or the Department.
- I may make a statement for the Department's record regarding the findings about me and any actions taken by me at that time or later to deal with the problems identified. Such statement becomes case record information for this or any other requests or authorizations for disclosure. For details, contact Child Protective Intake 1-800-452-1999 x2.
- This information will be used as part of the above agency's assessment of my suitability to provide services for children, adults, and families they serve.
- This information is subject to continuing confidentiality as provided by Maine statute, 22 M.R.S. §4008.
- This release will expire upon the disclosure of the information as authorized.
- ~~The fee for this process is \$15.00 per person as authorized by 22 M.R.S. § 4008(6) and 10-148 DHHS Chapter 202 (2004), payable to Treasurer State of Maine.~~ **Fees waived for your agency.**

PLEASE DO NOT LEAVE ANY SPACES BLANK

DATE OF BIRTH: _____ ALIASES (including maiden): _____

SIGNATURE: _____ DATE: _____

MAINE ADDRESS: _____

RESULT BELOW (To be completed by DHHS):

As of _____, this person was **NOT INVOLVED** in a substantiated Maine Child Protective Services case.

DHHS, OCFS, Child Protective Intake Staff

IF RESULT AREA IS BLANK, SEE REVERSE SIDE/ATTACHMENT →