Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Child and Family Services
11 State House Station
2 Anthony Avenue
Augusta, Maine 04333-0011
Tel.: (207) 624-7900; Toll Free: (877) 680-5866
TTY: Dial 711 (Maine Relay); Fax: (207) 624-5553

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

Agency/Provider to receive this information: **Agency ID#: 0**

Kimberly P. Martel
Tri-County Mental Health Services kmartel@tcmhs.org
P.O. Box 2008 207-344-1854
Lewiston, ME 04241-2008

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 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.

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→

*Must be signed by hand; unable to accept computer generated signature.