

**Idaho Department of Health and Welfare
CONSENT TO RELEASE INFORMATION**

My signature below serves as my consent to authorize the Idaho Department of Health and Welfare, Division of Family and Children’s Services, to conduct a search of the Child Abuse and Neglect Central Registry on myself and release the information to the individual(s)/organization(s) listed below. I also understand that all information provided on this form will be released to the organizations(s) below. I understand that the information may prove unfavorable to me. I agree to hold the Idaho Department of Health and Welfare and its staff harmless from liability associated with the release of information I have requested using this form. If it appears to me that the information in the Registry has not been updated or appears inaccurate, I will notify the Idaho Department of Health and Welfare immediately.

Submit Results To: City Clerk’s Office
 City of Ammon
 2135 S. Ammon Rd.
 Ammon, ID 83406
 Fax - 208-612-4014 OR
 Email - Ifolsom@ci.ammon.id.us

Please Print - Complete Spelling of the Name is Required - No Initials		
Name:	Date of Birth:	Sex:
Other Names Known By (Also Known As / AKA, Alias, Maiden):		Social Security Number:
Current Address:	Previous Addresses for Past 5 Years:	
Signature:		Date:

STATEMENT OF OATH

On this ____ day of _____, in the year _____, before me the undersigned, a Notary Public, personally appeared _____ known or identified to me to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same.

 Notary Public for the State of Idaho
 Residing at _____, Idaho
 My Commission Expires: _____

(SEAL)

This section is to be completed by an authorized Department of Health and Welfare employee only:

RESULTS OF THE SEARCH OF THE IDAHO CHILD ABUSE AND NEGLECT REGISTRY	
<input type="checkbox"/> The above name is not listed in the Child Abuse and Neglect Central Registry.	
<input type="checkbox"/> The above name is listed in the Child Abuse and Neglect Central Registry as having abused or neglected a child.	
<input type="checkbox"/> Other - See attached correspondence for additional information.	
Signature of Authorized IDHW Employee:	Date:

This form can be faxed to: Idaho State Department of Health and Welfare - 528-5950