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|  | **RELEASE OF INFORMATION CONSENT FOR CHILD ADVOCACY CENTERS**  State Form 57303 (7-23)  DEPARTMENT OF CHILD SERVICES |
| I, the undersigned, do hereby authorize the Indiana Department of Child Services (DCS) and the Child Advocacy Center (CAC) listed below to exchange information necessary to conduct an appropriate and thorough forensic interview, which may include a redacted Preliminary Report of Alleged Child Abuse or Neglect (SF114). Said information may include reported allegations of child abuse and/or neglect, the name of the alleged perpetrator, the name and date of birth of my child(ren), the name and contact information of my child’s parent, guardian, or custodian, and any history of past forensic interviews. The information may be released for the purpose of scheduling and completing a forensic interview. | |
| Child Advocacy Center Name | |
| Child Advocacy Center Address *(number and street, city, state, and ZIP code)* | |

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| First Name and Last Name of Child 1 | Date of Birth of Child 1 *(mm/dd/yyyy)* | |
| First Name and Last Name of Child 2 | Date of Birth of Child 2 *(mm/dd/yyyy)* | |
| First Name and Last Name of Child 3 | Date of Birth of Child 3 *(mm/dd/yyyy)* | |
| First Name and Last Name of Child 4 | Date of Birth of Child 4 *(mm/dd/yyyy)* | |
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| I understand this consent is valid for a period of sixty (60) calendar days from the date of the consent listed below, but the consent may be revoked in writing at any time prior to the expiration, except to the extent that action has already been taken. | | |
| Printed Name of Parent / Guardian | | |
| Parent / Guardian Signature | | Date *(month, day, year)* |