TWIN PINES FAMILY SERVICES, LLC

1 Washington St. Suite A. Hopwood, PA. 15445 Office: 724-439-HOME

www.twin-pines.org Fax: 724-439-4664

Authorization for Release of Information

I hereby authorize Twin Pines Family Services, LLC to

- ☐ Obtain
- ☐ Release Information to/from

_____

(Name of Organization)

Regarding: _____ DOB: _____ SSN: _____

Information to be obtained/released is:

ANY INVOLVEMENT WITH THE AGENCY THAT WOULD:

- PROCLUDE THIS PERSON FROM BECOMING A FOSTER PARENT WITH TWIN PINES FAMILY SERVICES, LLC.
- PROCLUDE THE APPLICANT(S) FROM BECOMING (A) FOSTER PARENT(S) WITH TWIN PINES FAMILY SERVICES, LLC BECAUSE THEY ARE AN ADULT HOUSEHOLD MEMBER OF A FAMILY THAT HAS APPLIED TO FOSTER.

IF INVOLVEMENT HAS BEEN FOUNDED, PLEASE INCLUDE DESCRIPTION(S) OF THE INCIDENT, THE DATE(S) OF THE INCIDENT(S), VERDICT, AND THE DATE(S) OF DISCHARGE ON THE CASE(S).

These records are requested to assure the safety of the child. Information requested concerning an individual's involvement with an agency may be used in determining suitability as a foster family.

- I have the right to revoke this authorization at any time.
- The revocation will not apply to information that has already been released in response to this authorization.
- Unless otherwise revoked, this authorization will expire in six (6) months.
- Authorizing the disclosure of this information is voluntary.

Signature: _____ Date: _____

Relationship: _____

Agency Representative: _____ Date: _____