

**Superior Court of Washington  
County of Spokane**

In re the Custody of:

Child(ren),

Petitioner(s),

and

Respondent(s).

**No.**

**Cover Sheet for Authorization  
to Release Information to the  
Court  
(Nonparental Custody)  
(CSAUTH)**

**Clerk's Action Required:  
Access is Restricted Per RCW  
13.50.100 and GR 22(C)(3)**

Attached is my written consent for release of information from DCFS/CPS for use in the above captioned cause of action. I understand that information from DCFS/CPS may be released to the parties, their attorneys and the guardian ad litem.

\_\_\_\_\_  
Signature of Petitioner or Lawyer/WSBA No.

\_\_\_\_\_  
Print or Type Name

\_\_\_\_\_  
Date



CHILDREN'S ADMINISTRATION  
**AUTHORIZATION TO RELEASE INFORMATION TO THE COURT**  
 (PER RCW 13.50.100)

<b>AUTHORIZATION TO DISCLOSE RECORDS OF:</b>			
NAME LAST	FIRST	MIDDLE	DATE OF BIRTH
The following information may help in locating records:		FORMER NAMES	
CLIENT IDENTIFICATION NUMBER	OTHER IDENTIFICATION NUMBER	DATES OF SERVICE	LOCATION OF SERVICE
<b>DISCLOSE TO:</b>			
NAME LAST	FIRST	MIDDLE	TITLE
<b>FAMILY LAW CENTER</b>			
ORGANIZATION OR BUSINESS NAME IF APPLICABLE <b>SPOKANE COUNTY SUPERIOR COURT</b>			
ADDRESS	CITY	STATE	ZIP CODE
<b>W 1116 BROADWAY</b>	<b>SPOKANE</b>	<b>WA</b>	<b>99260</b>
TELEPHONE NUMBER (INCLUDE AREA CODE)	FAX NUMBER (INCLUDE AREA CODE)	E-MAIL ADDRESS	
<b>509-477-5702 X: 0</b>	<b>509-477-5195</b>		
REASON FOR DISCLOSURE <b>NON-PARENTAL CUSTODY ACTION</b>			
<b>AUTHORIZATION:</b>			
<p>I authorize Children's Administration to release information from my records. I understand that information may be provided verbally or by computer data transfer, mail, fax or hand delivery. I understand this authorization allows the court to review the information and that it may be shared with other parties to the court action.</p> <p>I authorize the release of information regarding any "founded" CPS reports in which I am named as a subject since October 1, 1998, as well as information regarding any pending CPS investigations in which I am named as a subject.</p> <ul style="list-style-type: none"> <li>• This permission is valid for <input type="checkbox"/> 90 days or <input type="checkbox"/> until _____ (date or event).</li> <li>• I may revoke or withdraw my permission in writing at any time, but that will not affect information already disclosed.</li> <li>• I understand that my records may no longer be protected under the laws that apply to DSHS after this disclosure.</li> <li>• A copy of this form is valid to give my permission to disclose records.</li> </ul>			
AUTHORIZED BY (SIGNATURE)	DATE SIGNED	TELEPHONE NUMBER (INCLUDE AREA CODE)	
PRINT NAME	WITNESS/NOTARY (SIGN AND PRINT NAME, IF APPLICABLE)		
<p>If I am not the person who is the subject of the records, I am authorized to sign because I am the: (attach proof of authority)</p> <p><input type="checkbox"/> Parent of minor                      <input type="checkbox"/> Legal Guardian                      <input type="checkbox"/> Personal Representative</p> <p><input type="checkbox"/> Other:</p>			

**Notice to those receiving information:** If these records contain information about HIV, STDs, or alcohol or drug abuse, you may not further disclose that information under federal and state law without specific permission of the subject and meeting specific legal requirements.