



I/We understand that this family profile/home study contains information protected by federal law, specifically the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The information pertains to my/our health and to the health of children in my/our home. I/We give permission for this information to be released to the county and the court of referral or to county and private agencies for the purpose of matching my/our family with children in the foster care system for temporary care or for adoption. I/We understand that this release will be valid for three years, which is the length of the approval period, unless I/we withdraw the release in writing.

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Parent signature

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Date

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Parent signature

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Date

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Witness signature

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Date