

**KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES  
ADULT PROTECTIVE SERVICES**

Attachment 1

**RELEASE OF INFORMATION**

PLEASE PRINT THE FOLLOWING INFORMATION – Use “NA” if not applicable

I, \_\_\_\_\_, give permission for the release of any information concerning myself in the  
**(PRINT ONLY)**

Social and rehabilitation Services Adult Abuse, Neglect and Exploitation Central Registry to:

Contact Person (s) Shirley Arteaga

Your agency's name CILSWKS Phone (620) 276 – 1900

Agency/Individual address 1802 E. Spruce St., P.O. Box 2090, Garden City, KS 67846

**I understand that all information released will be for the exclusive and confidential use of the above named organization/person. I have read and understand this form and the information provided is true and correct to the best of my knowledge.**

Maiden Name and/or Other Names known by: \_\_\_\_\_  
**(PRINT ONLY)**

Any Other Married Name(s): \_\_\_\_\_  
**(PRINT ONLY)**

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_  
**(mm/dd/yyyy)**

Nationality: \_\_\_\_\_ Sex: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

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**For the Adult Abuse, Neglect and Exploitation Central Registry use only:**

Information contained in the APS Central Registry:

No Record ( ) \_\_\_\_\_ Yes ( ) \_\_\_\_\_

Perpetrator's Name: \_\_\_\_\_

County Reporting: \_\_\_\_\_

Date Report Received: \_\_\_\_\_

Case Finding: \_\_\_\_\_

Initial: \_\_\_\_\_ Date: \_\_\_\_\_