STATE OF KANSAS
Department for Children & Families
Office of Background Investigations

ADULT ABUSE, NEGLECT, EXPLOITATION CENTRAL REGISTRY RELEASE OF INFORMATION

OBI 10400
REV 2/21

I, _____, give permission for the release of information concerning
(PRINT Full Name)

myself in the Adult Abuse, Neglect, Exploitation Central Registry to:

Contact Person(s)* Nathan Fawson **Phone** 620-365-8641

Agency name Southeast Kansas Mental Health Center

Agency mailing address 304 N Jefferson Ave, Iola, KS 66749

Email address: **Will return via Encrypted email unless marked otherwise** sbennett1106@sekmhc.org

Maiden Name and/or Other Names Known By: _____
(PRINT ONLY)

Address: _____
Street **City** **State** **Zip Code**

DOB: _____ **SS#:** _____ ☐ Male ☐ Female
(mm/dd/yyyy) **(mark one)**

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 information provided is true and correct to the best of my knowledge.

I give permission for the release of any information concerning myself in the Adult Abuse, Neglect, Exploitation Central Registry each year while I am employed or associated with the above agency. ☐ **Yes** ☐ **No**

Signature: _____ **Date**: ____/____/____
(An Ink Signature or a Verified E-Signature is Required for Processing) **(mm/dd/yyyy)**

RETURN TO:

DCF.APSRegistry@KS.GOV
or
Adult Abuse Registry
555 S. Kansas Ave
Topeka, Kansas 66603-3444

(Please allow 3-5 days for processing email requests and an additional 5-7 days if returning by US Postal Service)

For Official Use Only: Mark in this area if PROHIBITED	**For Official Use Only: Mark in this area if CLEARED**