

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 North Jefferson Avenue-Iola, KS 66749  
**Email address:** Will return via Encrypted email unless marked otherwise acole@sekmhc.org

Maiden Name and/or Other Names Known By: \_\_\_\_\_  
**(PRINT ONLY)**

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

Street	City	State	Zip Code
DOB: _____ (mm/dd/yyyy)	SS#: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female (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:**  
Email: DCF.APSRegistry@ks.gov  
Mail: Office of Background Investigations  
Adult Abuse Registry  
P.O. Box 751043  
Topeka, Kansas 66675  
*(Please allow 3-5 days for processing email requests and an additional 5-7 days if returning by US Postal Service)*

<b>For Official Use Only: Mark in this area if PROHIBITED</b>	<b>For Official Use Only: Mark in this area if CLEARED</b>
---	--