

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)* Doug Wright, Interim CEO **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)

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