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

# ADULT ABUSE, NEGLECT, EXPLOITATION CENTRAL REGISTRY RELEASE OF INFORMATION

OBI 10400
REV 4/22

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, Executive Director **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**: _____ **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:**

**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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