



AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION
University of Washington Department of Psychiatry and Behavioral Sciences

PARENT-CHILD ASSISTANCE PROGRAM (PCAP)

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I, _____ give permission for Dr. Susan Stoner or a member of her
[SOCIAL WORKER NAME]

research team to interview the foster parent of _____ to
[CHILD LEGAL NAME]

collect information about this child for the PCAP research study. This authorization permits the child's foster parent to reveal information about this child, including: with whom the child has been living, healthcare, and childcare.

I have called the foster parent who has agreed that I may release the foster parent's name, address, and telephone number to the PCAP researchers. The child's foster parent isn't required to participate in the interview.

The researchers will only use information about this child for the research called "Parent-Child Assistance Program (PCAP). They won't use information about this child for any other reason, will keep it confidential, and won't give it to anyone who isn't connected to the PCAP study.

I am not required to sign this authorization. The researchers will only contact the child's foster parent and collect information about this child if I sign this authorization. I may cancel this authorization at any time by calling toll free or writing to the researcher listed above. If I cancel this authorization, the researchers will keep the information they already have about this child. They would not collect any additional information about this child.

This authorization expires 180 days after I sign, unless I cancel it before then.

SOCIAL WORKER'S Printed Name

SOCIAL WORKER'S Signature

Date

Cc: DCYF
Foster Parent
Researcher