RESET FORM

CONSENT TO DISCLOSURE OF INFORMATION

BRITISH COLUMBIA

Ministry of Children and Family Development

The personal information requested on this form is collected under the authority of and will be used for the purpose of administering the *Child, Family and Community Service Act* (CFCS Act) and/or the *Freedom of Information and Protection of Privacy Act* (FOIPP Act), and for administering the *Adoptions Act* (Adoptions only). Under certain circumstances, the collected information may be subject to disclosure as per the CFCS Act and/or the FOIPP Act. Any questions about the collection, use or disclosure of this information should be directed to the Director, Information, Privacy and Records Services Branch, (250)387-0820, PO Box 9702, Stn Prov Govt, Victoria, BC V8W 9S1. Any questions regarding the collection, use and/or disclosure of Adoption information may be referred to the Director, Child Protection Services, (250-387-7060), PO Box 9722 Stn Prov Govt, Victoria BC V8W 9S1.

Name of Agency/Service (If applicable): _____

I, _____ of _____
NAME ADDRESS

_____ , _____ consent to the disclosure of information about:
CITY/TOWN POSTAL CODE

☐ me

☐ a child who is in my legal care and is under 12 years of age.

☐ other (please specify):

For the following purpose: ☐ ADOPTION* **OR** ☐ OTHER (please describe below)

* If this consent is for the purpose of services related to Adoption, please check box A below, "All information in the custody or control of the Ministry of Children and Family Development".

I consent to the disclosure of:

A. ☐ All information in the custody OR control of the Ministry of Children and Family Development.

B. ☐ The following specific information only: (if more space is required, please attach an additional page)

C. ☐ all information with the exception of the following: (if more space is required, please attach an additional page)

To:

NAME	MAILING ADDRESS		
CITY/TOWN	POSTAL CODE	TELEPHONE NUMBER ( )	FAX NUMBER ( )
NAME	MAILING ADDRESS		
CITY/TOWN	POSTAL CODE	TELEPHONE NUMBER ( )	FAX NUMBER ( )

This consent is: ☐ One time only **OR** ☐ Continuing (one year validity if consent is for the purpose of services related to adoption)

SIGNATURE OF PERSON GIVING CONSENT	DATE (YYYY/MM/DD)
WITNESSED BY	DATE (YYYY/MM/DD)