CONSENT/RELEASE OF INFORMATION AUTHORIZATION FORM
FOR THE PENNSYLVANIA CHILD ABUSE HISTORY CLEARANCE

I, _____ (Applicant's Name) hereby authorize the Department of Public Welfare, ChildLine to release my Pennsylvania Child Abuse History Clearance information directly to LEHIGH VALLEY HEALTH NETWORK.

I understand that this information is confidential in nature pursuant to §6340 (relating to information in confidential reports) of the Child Protective Services Law (CPSL) (23 Pa.C.S Chapter 63) and will not otherwise be released by the LEHIGH VALLEY HEALTH NETWORK without my express authorization or pursuant to authorization by Title 55 of the Pennsylvania Code. I understand that the aforementioned information will not be released directly to me _____ (Applicant's Name) as stated in the Pennsylvania Child Abuse History Clearance application.

I understand that I will not receive a copy of my Pennsylvania Child Abuse History Clearance directly from ChildLine; however, I may request a copy of my Pennsylvania Child Abuse History Clearance from LEHIGH VALLEY HEALTH NETWORK upon written request.

I have read this Consent/Release of Information Authorization form and fully understand and agree to its content. I further understand and agree to all information and ramifications of the Pennsylvania Child Abuse History Clearance application as it otherwise relates to this consent.

_____ _____

Date Applicant's Signature

Name of Requesting Agency's Mailing Address:

LVHN-MEDICAL STAFF SERVICES
PO BOX 689
ALLENTOWN, PA 18105-1556