**DEPARTMENT OF CHILDREN AND FAMILIES**

Division of Management Services

**Complainant Consent / Release**

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

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| Name – Complainant | | | | | | | | | Today’s Date | | |
| Address – Complainant (Street, City, State, Zip Code) | | | | | | | | | | | |
| Telephone Number | | | | | Cell Phone Number | | | | | | |
| Email | | | | | | | | | | | |
| List the program(s) and / or person(s) name(s) you wish the Department of Children and Families (DCF) to contact or share information with regarding this matter, who may not be employed by DCF, (i.e., spouse, or other witnesses) for which this Consent / Release form authorizes. Also include the period for which the investigation should span if you wish for it to be restricted. | | | | | | | | | | | |
|  | **FOR EXAMPLE:** If you have received services for five years, but you only want the past twelve months investigated, you need to specify the period. You may also restrict a release for medical information to specific time frames and providers. It is your information and you have the rights to specify what information you wish to be released about you, and to whom it is released. | | | | | | | | | |  |
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| Please read the information below, initial the appropriate space, sign and date this form. | | | | | | | | | | | |
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| I have read the Notice of Investigatory Uses of Personal Information by the Department of Children and Families (DCF), contained in DCF Civil Rights Service Delivery Discrimination Complaint form (DCF-F-2466-E). As a complainant, I understand that in the course of a preliminary inquiry or investigation it may become necessary for DCF to reveal my identity to persons at the organization or institution under investigation. I am also aware of the obligations of DCF to honor requests under the Freedom of Information Act. I understand that it might be necessary for DCF to disclose information, including personally identifying details, which it has gathered as a part of its preliminary inquiry or investigation of my complaint. In addition, I understand that, as a complainant, I am protected by federal regulations from intimidation or retaliation for having taken action or participated in an action to secure rights protected by nondiscrimination statutes enforced by the federal government. | | | | | | | | | | | |
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| **CONSENT / RELEASE** | | | | | | | | | | | |
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| **CONSENT GRANTED.** I have read and understand the above information and authorize DCF to reveal my identity to persons at the organization or institution under investigation and to other federal agencies that provide federal financial assistance to the organization or institution or also have civil rights compliance oversight responsibilities that cover that organization or institution. I hereby authorize DCF to receive material and information about me pertinent to the investigation of my complaint. This release includes, but is not limited to, applications, case files, personal records, and or medical records. I understand that the material and information will be used for authorized civil rights compliance and enforcement activities. I further understand that I am not required to authorize this release, and I do so voluntarily. | | | | | | | | | | | |
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| Initial this line if you give consent. | |  | |  | | | | | | | |
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| **CONSENT DENIED.** I have read and understand the information and do not want DCF to reveal my identity to the organization or institution under investigation, or to review, receive copies of, or discuss material and consent information about me, pertinent to the investigation of my complaint. I understand that this is likely to make the investigation of my complaint and getting all the facts more difficult and, in some cases, impossible, and may result in the investigation being closed. | | | | | | | | | | | |
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| Initial this line if you **DO NOT** give consent. | | |  | | |  | | | | | |
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| Sign, date and return the Consent / Release form to: DCF Civil Rights Compliance Unit, 201 East Washington Avenue, P.O. Box 8916, Madison, WI 53708 or you may fax it to (608) 421-7423. | | | | | | | | | | | |
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| **SIGNATURE** – Complainant | | | | | | |  | Date Signed | |  | |