

Arkansas Department of Human Services Division of Children and Family Services Case File Request

Mothers Information:					
Mothers information:	Last	First	Middle	Date of Birth	
Fathers Information:					
	Last	First	Middle	Date of Birth	
Child(ren) Information				- 221.1	_
	Last	First	Middle	Date of Birth	
Child(ren) Information	n:	First	Middle	Date of Birth	-
(use second page if ne				שמני טו שונוו	
CHRIS Case Number	(if known):				
Name of person reque	esting case fi	ile:			
				Guardian Health Care Provider	
☐ School ☐ Re			torney Ad Lite	em for	
	_				
Phone number of Req	uestor:				
Please select how you	would like	the file sent	to you:		
□ Email					
 	Email Ad	ldress			
□ U.S. Mail					
	Street A	ddress		City	Zip
THE FOLLOWI	NG IS TO	BE COMPL	ETED ONLY	IN THE PRESENCE OF A NOT	ARY
G:	C A 1: 4				_
Signature of	Applicant			Date	
County of			State of Arkansa	as	
Acknowledged before m	ne, this		day of	,	·
L			My commiss	sion expires:	
Notary Public					

Please email this form to <u>ARAbuseNeglectRecords@dhs.arkansas.gov</u> or mail request to: DCFS Release of Information Unit

PO Box 1437 Slot S-555