

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Accreditation Organization Release of Information Consent

I, _____, hereby consent to the exchange of information between
CEO (or equivalent)

_____ and
Accrediting Agency

The Arkansas Department of Human Services for the specific purpose of obtaining or sharing information relevant to Behavioral Health Agency Certification.

I consent to information regarding my agency's national accreditation or state certifications being released by facsimile (FAX) _____ Yes _____ No.

I understand that the information I authorize for release may include sensitive information. I understand that a facsimile of this consent is considered as valid as if it were the original.

Signature of CEO (or equivalent)

Date

Signature of Witness

Date