

INFANT RELEASE AUTHORIZATION

To be submitted by the hospital to the Nevada State Division of Child and Family Services **BEFORE** physical custody of a child is released to a person other than a parent or relative.

I. PARENT'S AUTHORIZATION (To be filled out completely before parent signs)

I, _____, the mother of _____
Born to me at _____ Hospital on _____ authorize
said hospital to release my child to _____
Date
Name

Permanent Address: Street _____ City _____ State _____ Zip _____
For the purpose of _____
e.g.: adoption, transfer to another hospital, foster care, boarding care pending adoption

This consent is for the release of my child from the hospital only and does not constitute a consent or relinquishment of my child for adoption.

Dated this _____ day of _____, 20_____
Signature of mother (even if minor) or authorized person having legal custody of child

Witness _____
Witness Signature _____ Permanent address of mother or guardian _____

II. ACKNOWLEDGEMENT BY PERSON(S) RECEIVING CHILD

We (I) have on this _____ day of _____, 20_____
received from _____
Hospital

The child _____ for the purpose of _____

Witness _____
Signature(s) or person(s) receiving child

Identification of person (s) receiving child: _____

Driver's Lic. No. _____

So. Sec. No. _____
Permanent address: Street _____ City _____ State _____

Other _____

III. REPORT OF HOSPITAL

Name of hospital _____ Street _____ City _____ State _____

Name of mother _____ Current address _____

Date of arrival _____ Date of discharge _____

Attending physician _____
Name Address

Name of Child's father _____ Address _____

Child's name _____ Sex _____ Date Child released _____

Signature of administrator or designated representative

Mail or fax a copy to: **DIVISION OF CHILD AND FAMILY SERVICES**, Social Services Adoption Specialist
4126 Technology Way, 3rd Floor, Carson City, NV 89706
Fax: (775) 684-4456