

# INFANT RELEASE AUTHORIZATION

To be submitted by the hospital to 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 \_\_\_\_\_ Date \_\_\_\_\_ authorize  
said hospital to release my child to \_\_\_\_\_ Name \_\_\_\_\_

\_\_\_\_\_ Number \_\_\_\_\_ Street \_\_\_\_\_ Permanent address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
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 \_\_\_\_\_ Permanent address of mother or guardian \_\_\_\_\_

## II. ACKNOWLEDGMENT 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) of person(s) receiving child \_\_\_\_\_

Identification of person(s) receiving child: \_\_\_\_\_

Driver's Lic. No. \_\_\_\_\_

Soc. Sec. No. \_\_\_\_\_ No. \_\_\_\_\_ Street \_\_\_\_\_ Permanent Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Other \_\_\_\_\_

## III. REPORT OF HOSPITAL

\_\_\_\_\_ Name of hospital \_\_\_\_\_ No. \_\_\_\_\_ Street \_\_\_\_\_ City and 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 \_\_\_\_\_

DISTRIBUTION: Original-Hospital; One copy-Nevada Division of Child and Family Services; One copy-Person Receiving Child