STATE OF DELAWARE
DEPARTMENT OF SAFETY AND HOMELAND SECURITY
DIVISION OF STATE POLICE
P.O. BOX 430
DOVER, DELAWARE 19903

AUTHORIZATION FOR RELEASE OF INFORMATION

FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX
SOCIAL SECURITY NUMBER	DATE OF BIRTH	PLACE OF BIRTH	
CURRENT ADDRESS (NUMBER, STREET, APT NO., CITY OR TOWN, STATE, AND ZIP CODE)			
SELECTIVE SERVICE NUMBER	BRANCH OF SERVICE	VETERAN'S ADMINISTRATION FILE #	

I, _____ do hereby authorize a review and full disclosure of all records, or any part thereof, concerning myself by/to any duly authorized personnel of the Delaware State Police and/or any medical provider contracted by the agency, whether the said records are public or private, and including those which may be deemed to be of a privileged or confidential nature. The intention of this authorization is to provide information which will be utilized for investigative resource material for my employment with the Delaware State Police.

I authorize the full and complete disclosure of the records of educational institutions, and the records of commercial or retail mercantile establishments and retail credit agencies; medical and psychiatric consultation and/or treatment, including those of hospitals, clinics, private practitioners, the United States Veteran's Administration, and all military and psychiatric facilities; public utility companies; employment and pre-employment records including background investigation reports, the results of polygraph examinations, efficiency ratings, complaints or grievances filed by or against me; records of complaints of a civil nature made by or against me, and including, but not limited to the records and recollections of attorneys at law, or of other counsel who represent or have represented myself or another person in any case in which I presently have, or have had an interest.

I authorize the National Personnel Records Center (St. Louis, Missouri), or other custodian of military record to provide to the Delaware State Police, information or photocopies from my military personnel and related medical records. This could include a photocopy of my DD Form 214 (Report of Separation).

A photocopy of this release form will be valid as an original hereof, even though the said photocopy does not contain an original writing of my signatures. I agree to indemnify and hold harmless employees, from and against all claims, damages, losses, and expenses, including reasonable attorney's fees arising out of or by reason of complying with this request.

Applicant Signature **Date**

(NOTARY SEAL)

Signature of Notary Public **Date**