

AUTHORIZATION FOR RELEASE OF INFORMATION

Carefully read this authorization to release information about you before signing.

I authorize any investigator, special agent or other duly accredited representative of the authorized Federal agency conducting my background investigation, to obtain any information relating to my activities from individuals, schools, residential management agents, employers, criminal justice agencies, credit bureaus, consumer reporting agencies, collection agencies, retail business establishments, or other sources of information. This information may include, but is not limited to, my academic, residential, achievement, performance, attendance, disciplinary, employment history, criminal history record information, and financial credit information. I authorize the Federal agency conducting my investigation to disclose the records of my background investigation to the requesting agency for the purpose of making a determination of suitability or eligibility for employment.

I understand that, for financial or lending institutions, medical institutions, hospitals, health care professionals and other sources of information, a separate specific release will be needed and I may be contacted for such a release at a later date. Where a separate release is requested for information relating to mental health treatment or counseling, the release will contain a list of the specific questions, relevant to the job description, which the doctor or therapist will be asked (if applicable).

I further authorize any investigator, special agent, or other duly accredited representative of the U.S. Office of Personnel Management, the Federal Bureau of Investigation, the Department of Defense, the Defense Investigative Service and any other authorized Federal agency, to request criminal record information about me from criminal justice agencies for the purpose of determining my eligibility for assignment to, or retention in a Nonappropriated Fund position. I understand that I may request a copy of such records as may be available to me under the law.

I authorize custodians of records and other sources of information pertaining to me to release such information upon request on the investigator, special agent, or other duly accredited representative of any Federal agency authorized above regardless of any previous agreement to the contrary.

I understand that the information released by records custodians and sources of information is for official use by the Federal Government only for the purpose provided in this release statement and that it may be redisclosed by the Government only as authorized by law.

Copies of this authorization that show my signature are as valid as the original release signed by me. This authorization is valid for five (5) years from the date signed or upon the termination of my affiliation with the Federal Government, whichever is sooner.

Signature (Sign in Ink)	Full Name (Type or Print Legibly)	Date Signed
Other Names Used	Social Security Number	
Current Address (Street, City, State, Zip Code)	Date of Birth	
Current Drivers License Information (Number, State, and Expiration date)		

The privacy act of 1974 affects this authorization. Do not release personal data outside the DOD without consent of the individual. AFR 12-35, Para 19a and 19b apply.

Record Exists

No Record Exists

Security Forces Signature/Date