



## RELEASE OF INFORMATION AUTHORIZATION FOR BACKGROUND CHECK

I, \_\_\_\_\_, authorize and consent to any person provided a copy or facsimile of this Release of Information Authorization for Background Check by an authorized representative of the Department of Health & Social Services, to disclose any information regarding me in relation to civil court information, criminal justice, juvenile justice, protective service and licensing records. I understand any person providing information or records in accordance with this authorization is released from any and all claims or liability for compliance. I understand that this information may otherwise be confidential and that I am waiving that confidentiality and any claim I may have with regard to release of these records. I understand information obtained through this Release of Information Authorization for Background Check will be held in confidence in accordance with DHSS guidelines.

I, \_\_\_\_\_, authorize and consent to the department marking my name in the Alaska Public Safety Information Network (APSIN) under 7 AAC 10.915(e).

This form must be signed; if the individual is 16-17 years of age, a parent signature must also be included.

\_\_\_\_\_  
Applicant Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Applicant SSN

\_\_\_\_\_  
Parent Printed Name, if applicable

\_\_\_\_\_  
Parent Signature