WINFIELD MOUNT
HEALTH SERVICES, INC.
YOUR HOME AWAY FROM HOME
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AUTHORITY FOR RELEASE OF INFORMATION

TO WHOM IT MAY CONCERN:

I hereby authorize any investigator or duly accredited representative of the Department of Behavioral Health and Developmental Services (DBHDS) bearing this release, or a copy thereof, to obtain any information from law enforcement/criminal justice agencies and report the results of such search to the agencies, facilities, or individual(s) authorized to receive same. I hereby direct you to release such information upon request of the bearer. I understand that the information released is for official use by DBHDS and may be disclosed to such third parties as indicated below in the fulfillment of official responsibilities.

I hereby release any individual, including records custodians, from any and all liability for damages of whatever kind or nature which may at any time result to me on account of compliance, or any attempts to comply with this authorization. Should there be any questions as to the validity of this release, you may contact me as indicated below.

Signature (Full Name): _____

Print Name (Full Name): _____

Other Names Currently or Previously Used (Religious, etc.): _____

Current Address: _____

_____

Telephone Number: _____ **Date:** _____

Release to: WINFIELD MOUNT HEALTH SERVICES, INC #3003

(Licensed Provider Name and Provider Number)