

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize DEAP/Lifespan Respite to conduct a criminal records background check through the Department of Justice, Child/Adult Protective Services, and the Department of Motor Vehicles. Any information obtained will remain confidential.

I hereby authorize the release of information to be gathered through references, previous employers and law enforcement agencies.

I release DEAP/Lifespan Respite and any organization, institution or any other person supplying information, as authorized above, from any liability for damages which may result from furnishing the information requested.

	Print Full Name		
	Present Address	Present Address	
	Any other name(s) used		
	Social Security Number_		
	Birth Date	MaleFemale	
	Driver's License Number_		
	Signed:	Date	
	(*To be signed in	front of a Notary)	
**TO BE COMPI	LETED BY A NOTARY PUBLIC:		
State of Montana County of		_	
Signed or acknowl	ledged before me on	by	
	(Date)	(Name of person signing document)	
	MONTANA NOTARIES N	MUST COMPLETE THE FOLLOWING IF NOT PART OF STAMP AT LEFT	
		(Printed name of notary public) Notary public for the state of	
		Residing at:	
		My commission expires:	
*****	********	**********	
Office Use Only			
D.M.V	CPS/APS	Dept. of Justice	
Name of Staff re	equesting information		
Program of Serv	rice	Coding	