**MARYLAND STATE POLICE**

# Authorization for Release of Information

I, _____,do hereby authorize a review and full disclosure of all records, or any part thereof, concerning myself by/to any duly authorized agent of the Maryland State Police, 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 resources material.

I authorize the full and complete disclosure of the records of educational institutions, financial or credit institutions, and the records of commercial or retail mercantile establishments and retail credit agencies; real or personal property records; medical and psychiatric consultation and/or treatment, including those of hospitals, clinics, private practitioners, the U.S. Veterans' Administration, and all military and psychiatric facilities, and including medical records that the health care provider has received from another provider; 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; internal affair investigations/reports; complaint, arrest, trial and/or conviction records for alledged or actual violations of law including criminal and/or traffic records; records of complaints of a civil nature made by or against me and including, 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 release to the Maryland State Police, information or photocopies from my military personnel and related medical records, or only the following information/records _____. This could include a photocopy of my DD214, 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 signature. Facsimile cover pages stating the name of a health care provider are considered part of this release form.

I agree to indemnify and hold harmless the person to whom this request is presented and his agents and employees, from and against all claims, damages, losses and expenses, including reasonable attorneys' fees arising out of or by reason of complying with this request. This authorization is valid for one year from the date of my signature.

SIGNATURE: _____ DATE: _____

MAIDEN NAME: _____

ADDRESS: _____

DOB: _____ Last Four of SSN: _____

## Notary Public Certification

STATE OF MARYLAND COUNTY OF _____

Personally appeared before me, a Notary Public, in and for said county and state, on this _____ day of _____, 20_____, the within named _____, known to me, or satisfactorily proven, to be the person whose name is subscribed to the within instrument and who acknowledges that he/she/they (strike one) executed the same for the purposes therein contained.

_____

NOTARY PUBLIC

Official Seal
Must be Affixed

Print Name: _____

My Commission Expires: _____

**MSP 81 (08-18)**