Once this form is Notarized, return to Kinship Partners

Everyone living in the household full-time over the age of 18 must complete this form and have it notarized.

AUTHORIZATION FOR RELEASE OF INFORMATION

TO:
- Mn Dept of Pub Safety, Bureau of Crim Appr
  CJIS—Criminal History Access Account
  1430 Maryland Ave East
  St. Paul, MN 55106
- Local Sheriff's Department
- Local Police Department/Driving Record
- County Child Protection

FROM: "NON PROFIT ORGANIZATION"
T188294606
Kinship Partners, Inc.
910 Pine Street
PO Box 642
Brainerd, MN 56401
218-829-4606

NAME_____
Last First Middle

_____
Any other name known by, ie: former married name, maiden, etc.

Address_____
Street City State Zip Code

Date of Birth _____ Social Security Number_____ Sex (M) (F)
(Optional)

Driver's License #_____

County _____Length of residency in current county_____, if under 5 years, former counties_____

I hereby authorize the Bureau of Criminal Apprehension to release the information identified in connection with the evaluation of my application as a volunteer with Kinship Partners of Crow Wing and Cass Counties. The information to be released includes: a driving record check, criminal history, arrests, child protection records, and criminal charges or convictions.

1. I understand the information to be released, the purpose and use of the released information, and any known consequences of this release. The information to be released is private and any subsequent use and release is controlled by the Minnesota Data Practices Act. (MN Stat, Chap 13)
2. I understand that I have the right to refuse to release this information. If I refuse to release this information, it will not be possible for this office to process this application.
3. I understand that I may withdraw this consent upon written notice (not retroactive) and that consent will automatically expire within 1 year after the date of my signature.

I further authorize to provide Kinship Partners with photocopies of any of the above information kept by you regarding me. I ask that you cooperate with them fully in disclosing to them all such information that is in your possession. The undersigned person recognizes that the purpose for which the above described information may be used by suitability of the undersigned to become a volunteer with Kinship Partners.

Signature _____Date_____
Must be signed and dated in front of Notary

Notary _____Seal

Dated_____