# DEPARTMENT OF STATE HOSPITALS
**OFFICE OF PROTECTIVE SERVICES**

## AUTHORIZATION TO RELEASE INFORMATION AND WAIVER

To Whom It May Concern:

I hereby authorize any Peace Officer or other authorized representative of the Department of State Hospitals, Office of Protective Services bearing this release, or a copy of it, within 365 days of its date, to obtain any information in your files pertaining to my employment, credit, or education records, including but not limited to, academic achievement, attendance, athletic, personal history, performance reports, background investigations, CVSA/polygraph reports, disciplinary records, and credit records.

In connection with this, I AUTHORIZE RELEASE OF ANY AND ALL INFORMATION YOU MAY HAVE CONCERNING ME, INCLUDING BUT NOT LIMITED TO, INFORMATION OF A CONFIDENTIAL OR PRIVILEGED NATURE; OR ANY DATA OR MATERIALS WHICH MAY HAVE BEEN SEALED OR AGREED TO BE WITHHELD PURSUANT TO ANY PRIOR AGREEMENT OR COURT PROCEEDINGS INVOLVING DISCIPLINARY MATTERS. I waive any and all rights to have any record(s) or information discovered or disclosed by a notice motion pursuant to Evidence Code Section 1043 and hereby authorize the disclosure of all records, to which, as an employee, the undersigned would have or did have access.

I hereby direct you to release this information upon request of the bearer. This release is executed with full knowledge and understanding that the information is for the official use of the Department of State Hospitals, Office of Protective Services.

I hereby release you, as the custodian of such records, and any school, college, university, or other educational institution, hospital, or other repository of medical records, or retail business establishment, including its officers, employees, or related personnel, both individually and collectively, from any and all liability for damage of whatever kind, which may at any time result to me, my heirs, family, or associates, because of compliance with the authorization and request to release information, or any attempt to comply with it. Should there be any questions as to the validity of this release, you may contact me as indicated below.

It is understood and acknowledged by me that any information secured, pursuant to this required background investigation, which would negatively reflect on my fitness for duty, will be forwarded to my current law enforcement employer.

I understand that I have the right to receive a copy of this authorization and acknowledge that I have received a copy.

DATED: _____ SIGNED: _____
**APPLICANT SIGNATURE – SIGN IN PRESENCE OF NOTARY PUBLIC**

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document, to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

STATE OF _____, COUNTY OF _____

On _____, before me, _____, Notary Public,

Personally appeared _____, who proved to me on the basis of satisfactory evidence, to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument the person or the entity upon behalf of which the person acted, executed the instrument. I CERTIFY UNDER PENALTY OF PERJURY under the laws of the State of California, that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

_____
SIGNATURE OF NOTARY SEAL