

CONTINENTAL NURSES
(888) 894-2900 (phone)
(888) 894-2073 (fax)

Division of Health Improvement
CAREGIVERS CRIMINAL HISTORY SCREENING PROGRAM

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ / _____ / _____
(NAME) (Must be typed or printed legibly) Social Security # Date of Birth

Pursuant to NSMA 1978, Section 29-10-6(a) (Repl. Pamp. 1990), of the New Mexico Arrest Record Information Act, hereby appoint:

THE DEPARTMENT OF HEALTH

As an authorized agent for me for the purpose of inspection (and/or obtaining copies) any New Mexico arrest fingerprint card supported record information maintained by the Department of Public Safety and the Federal Bureau of Investigations, including information concerning felony or misdemeanor arrests.

To the custodian of records in question, I hereby direct you to release such information to the Authorized Agent as described above.

I hereby release the custodian or custodians of such records and the Department of Health and the State of New Mexico, including any of their agents, employees, or representatives in any capacity, from any and all claims of liability or damage of whatever kind or nature, which at any time could result to me, my heirs, assigns, associates, personal representative or representatives of any nature because of compliance by said custodian or custodians with the "Authorization for Release of Information" and my request contained herein for this release or because of any use of these records. This release is binding now and in the future, on my heirs, assigns, associates, personal representative or representatives of any nature.

(Signature)

(Date)

ATTENTION NOTARY: Ensure document is signed in your presence and Name, Social Security Number and Date of Birth information is verified with a valid ID.)

Subscribed and sworn to before me this _____ day of _____, 20_____

(Seal)

Notary Public

My Commission Expires: _____