

# PRE-EMPLOYMENT BACKGROUND INVESTIGATION

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## AUTHORIZATION TO RELEASE INFORMATION AND RECORDS

TO WHOM IT MAY CONCERN:

I have submitted an application for the position of a Police Officer with the Susquehanna Area Regional Airport Authority Police Department, in Middletown, Dauphin County, Pennsylvania. This Letter, or a copy of it, shall constitute my formal Authorization for you to disclose to any Investigator any Information or Records (defined as those items listed below) requested relating to my:

Medical records	Personal contacts
Job performance	Conduct
Arrests and convictions	Disciplinary records
Credit history	Background inquiries and investigations
Academic	General reputation
Driving history	Bank statements
Military service	Financial documents

I hereby waive any and all expectation of, or entitlement to, privacy afforded me by Federal, State, or local laws or policies, including HIPPA.

This Authorization specifically includes any and all privileged information of a confidential nature, in addition to photocopies of any relevant Information or Records as required by any Investigator.

I execute this Authorization with full knowledge that the Information or Records may be disclosed and used by third parties, namely the Investigator and its agents. I do hereby and forever release you as custodian of records, acquaintance, friend, family member, attorney, doctor, counselor, therapist, physician, employer, supervisor, co-worker, credit bureau, educational institution, hospital, or other repository, personally, individually, and collectively from any and all liability for damages which could result from furnishing the Information or Records, or from any subsequent use of such information in determining my qualifications as a Police Officer. I release any cooperating person from any and all liability for damage to me, my heirs, my associates, or my family which resulted from compliance with this Authorization.

Additionally, I specifically authorize the National Records Center located in St. Louis, Missouri, or any other repository or custodial facility for military records, to release information, photocopies, or faxes from my military history and personnel files, as well as any related medical records, including an unaltered photocopy of my DD214. This Authorization shall expire one year from the date it is signed by me.

NAME: \_\_\_\_\_ SSN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ DOB: \_\_\_\_\_

DRIVERS LIC #: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_ DATE: \_\_\_\_\_