



**AUTHORIZATION FOR RELEASE OF INFORMATION
FROM THE BUREAU OF CRIMINAL APPREHENSION
LOCAL LAW ENFORCEMENT AGENCIES AND COUNTY
SOCIAL SERVICE AGENCIES**

As required by Minnesota Statute 245C Chisago County is required to conduct a background check on its service providers. By signing this release the application hereby authorizes the Bureau of Criminal Apprehension, Court Administration, Local Law Enforcement Agencies and Social Service Agencies in areas I live or have lived to release any information they have regarding arrests; investigations; and/or convictions of all criminal history conviction data, to include juvenile delinquency matters; or information regarding maltreatment assessments. This information may be released to the Minnesota Department of Human Services and to the Chisago County Department of Health & Human Services. The information will remain in the licensing file and will be classified as private material. The information will be used in connection with the evaluation for licensure and/or registration as a legal/legal non-licensed provider within one or more of the following program areas:

Provider Name _____ Case # _____
(if applicable)

<input type="checkbox"/> Family Foster Care	<input type="checkbox"/> Relative Foster Care
<input type="checkbox"/> Family Day Care Home	<input type="checkbox"/> Emergency License
<input type="checkbox"/> Adult Foster Care	<input type="checkbox"/> Supervised Visitation
<input type="checkbox"/> Visitation	<input type="checkbox"/>

Requested by	Social Worker
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Applicant please supply the following information: Gender: _____ Race: _____

Name: _____ Birth Date: _____
Last First Full Middle Maiden

Other Names Known By: _____

Address:

Street City State Zip County

Drivers License: _____ Social Security Number: _____

Address of services:

(If different from above) Street City State Zip County

Phone Number : _____

Other addresses you have lived at in the past five years:

1. Address From: To:		3. Address From: To:	
City / State Zip Code		City / State Zip Code	
County		County	
2. Address From: To:		4. Address From: To:	
City / State Zip Code		City / State Zip Code	
County		County	

Use additional sheet of paper if necessary.

By signing below, I acknowledge and fully understand:

- That the State of Minnesota and Federal privacy laws protect my records and that these records can be released only if I give my written permission or if the law(s) requires it.
- That I can refuse to sign this release, but that if I do, no one in my household/agency will be able to be authorized as a child/adult care provider for a family receiving [county and/or state funds including child care assistance](#).
- That I can cancel this release with written notice at any time, but that this cancellation will not affect information that has already been requested or released. If I cancel this release, it may prevent a member of my household/ organization from being authorized as a provider for a family receiving [county and/or state funds to include child care assistance](#).
- That this release does not authorize redisclosure to any person or entity other than those listed above. However, information disclosed under this release may be subject to redisclosure, including as may be required or authorized by law. Once information is provided to a person or entity other than those listed above, it is no longer protected by this release.

Parent/Guardian Signature (if minor) **Date**

Applicant Signature **Date**

THE EXPIRATION DATE OF THIS AUTHORIZATION SHALL BE ONE YEAR
FROM THE SIGNATURE DATE.