AUTHORITY FOR RELEASE OF INFORMATION

I authorize the North Carolina Department of Justice through the STATE BUREAU OF INVESTIGATION, Special Operations Division, to perform a fingerprint search of the State's criminal history record file and, if applicable, a fingerprint search of the FEDERAL BUREAU OF INVESTIGATION'S files for a national criminal history record check in connection with my application for employment, or my employment with **BLACK MOUNTAIN NEURO-MEDICAL TREATMENT CENTER** pursuant to NCGS 114-19.6, 114-19.2, 115C-332, and 143B-146.16.

(Type or Print clearly)

Last Name	First	Middle	Maiden
_____	_____	_____	_____

Social Security Number (Optional*)	Date of Birth	Sex	Race
_____	_____	_____	_____

I understand that the North Carolina State Bureau of Investigation, Special Operations Division, and its officials and employees shall not be held legally accountable in any way for providing this information to the above named agency, and I hereby release said agency and persons from any and all liability which may be incurred as a result of furnishing such information. I further understand that the agency cannot provide a **hard copy** of the results of this criminal history record check to me.

*Disclosure of social security number is entirely voluntary and not required. If disclosed, the social security number will be utilized to assist with accurate identification/exclusion of possible criminal history records.

Applicant's/Employee's Signature

_____

Date

_____

This form must be maintained on file with the above named agency for one year. **Do not mail this form or a copy of this form to the State Bureau of Investigation.**