INSTRUCTIONS TO THE APPLICANT

The information you provide in this personal history statement will be used in the investigation of your background to determine your suitability for the position of which you have applied. Please fill out the application completely and accurately.

Keep in mind that:

1. All statements are subject to verification.
2. **Deliberate inaccuracies or omissions will bar or remove you from further consideration for employment.**
3. **Failure to follow instructions or answer questions completely and accurately may bar or remove you from further consideration for employment.**
4. **All** time periods in your background **must** be accounted for.
5. You are responsible for updating this Personal History Statement in the event changes occur during the background investigation (e.g. change of address, arrests or legal actions, personal/family changes, telephone number changes, etc.). Notification of such changes must be submitted in writing to the Johnston Police Department to the attention of the Administrative Division.
6. If you have any questions regarding any section or part of this application, do not hesitate to contact this office at (401) 231-4210 for clarification. Our personnel will be glad to take time to explain any section or part of the application that you do not fully understand.

It is to your advantage to respond openly. Any negative factor in your background will be evaluated in terms of the circumstances and facts surrounding its occurrence and the degree of relevance to the position for which you have applied. During the investigation the investigator will inquire into the facts surrounding such an occurrence. Any evaluation will then be made of the relevance of these facts to the requirements of the job.

You may complete this packet electronically or if by hand, please **CLEARLY PRINT** your responses in **blue ink** **ONLY**. If a question does not apply to you, write "N/A" (not applicable) in the space provided for your answer. If you need more space to respond to a question, attach a separate sheet of paper and refer to the section heading or number. We strongly recommend that you preview this form before submitting.

JOHNSTON POLICE DEPARTMENT

Chief of Police, Mark A. Vieira

Personal

(If additional space is needed at any point in the application, attach typed/clearly written page(s) at the end of the packet, and be sure to reference the section and question being answered)

Name:	Last	First	Middle
Other Names you have used or have been known by: (including nicknames)			
Date of Birth:		Place of Birth:	
Social Security Number:		Blood Type:	

Phone/Contact

Cellular:		Home:		Work:	
E-mail Addresses:					
Social Media Account Names: Facebook, LinkedIn, Twitter, YouTube, Instagram, Google+, TikTok, WhatsApp, Pinterest, Snapchat, Tumblr, Flickr, etc.					

Description

Height	Weight		Eye color	Hair Color
		lbs.		
List any scars, marks and/or tattoos (and location if visible)				
Dominate Hand:				

Residence

Please list all residences since 16 years of age. Include all of those while in college and the Armed Forces. Begin with your most current residence. (Do NOT use PO BOXES)

Address of Residence	City, State, & Zip	Dates (mm/yy)	
		From	To

The Town of Johnston is an Equal Opportunity Employer encouraging women, minorities and individuals with disabilities to apply. Applicants are considered for positions without regard to race, color, religion, sex, national origin, marital or veteran status.

Spouse/Dependents

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow ☐

List information on your current spouse (include maiden name), all of your children, include step-children and adopted children. If engaged, list fiancé. If in a dating relationship, list partner.

Name	Address	Age	Relationship

If divorced or separated, list all previous spouses and dates of separation or divorce.

Current Name	Current Address	Phone Number	Date of Separation/Div. (mm/yy)

Provide the appropriate information pertaining to any individuals with whom you have resided with in the last three (3) years (excluding relatives listed above).

Name	Address of Residence	Phone #	Dates (mm/yy)

In the spaces below, list the requested information for your family members (even if deceased) to include mother, father, guardian, step-parents, parents-in-law, foster parents, brothers, sisters and step-siblings. Include their relationship to you and at least two (2) phone numbers.

Name/Relationship	Address	Phone	
		Home:	
		Cell:	
		Home:	
		Cell:	
		Home:	
		Cell:	
		Home:	
		Cell:	
		Home:	
		Cell:	
		Home:	
		Cell:	
		Home:	
		Cell:	
		Home:	
		Cell:	

Education

Please indicate below all the schools you have attended beginning with high school.

Name of School	Location of School (City and State)	Date Attended (mm/yy) From	To	Did you Graduate? Please list any Degree earned

If you do not possess a college degree, how many college semester credits have you successfully completed/earned?		credits

Have you ever been suspended or expelled from any high school or post-secondary school? (Post-Secondary schools include colleges and universities, graduate schools and business/vocational schools or any formal education beyond the high school level.)	Yes ☐ No ☐

If "Yes," please explain (include school, date and circumstances).

List any organizations, clubs, fraternities, sororities, civic groups and/or social clubs of which you are now or have ever been a member of or associate with. Indicate any office or position held.

Military

Have you ever served in the Armed Forces, National Guard and/or Military Reserves?	Yes ☐ No ☐

If "Yes", please supply the following information:

Branch of Service	Service Number	Dates of Service (mm/yy) From	To	Type of Discharge or Current Status

Are you currently participating in any military reserve or National Guard program?	Yes ☐ No ☐

Military Continued

Did you receive any disciplinary actions while in the military? If "Yes," please explain.	Yes ☐ No ☐

List your rank, Military occupation, Specialty (MOS) and describe your duties:

List all duty stations, including Basic Training and other schools:

Military Installation	City/State/Country (if applicable)	Assignment

Please list those individuals in the military who know you well enough to provide accurate information about you.

Name	Address	Phone		Years known (mm/yy) From	To
		Home:			
		Work:			
		Home:			
		Work:			
		Home:			
		Work:			
		Home:			
		Work:			
		Home:			
		Work:			
		Home:			
		Work:			
		Home:			
		Work:			

Financial

Please fill in the financial statement below. Be complete and accurate.				
Current Gross Monthly Income		Current Monthly Expenditures		
Your current monthly salary:		Real Estate (mortgage) payment(s)/Rent (please specify):	Mortgage ☐ Rent ☐	
Spouses current monthly salary (if applicable):				
Other monthly income - describe:	(Enter info. below)	Other monthly payments - describe: (Estimated monthly cost of living including utilities, food, gas, home/car maintenance, entertainment, etc. and any other obligations)		(Enter info. below)
Total Monthly Income:		Total monthly expenditures:		

Savings Account(s)?	Yes ☐ No ☐	Real Estate indebtedness?	Yes ☐ No ☐
Checking Account(s)?	Yes ☐ No ☐	Long-term loans?	Yes ☐ No ☐
Real Estate?	Yes ☐ No ☐	Charge Accounts?	Yes ☐ No ☐
Stocks/Bonds?	Yes ☐ No ☐	Other Liabilities (list)?	Yes ☐ No ☐
Autos?	Yes ☐ No ☐		Yes ☐ No ☐ N/A ☐
Other Assets (list)?	Yes ☐ No ☐ N/A ☐		Yes ☐ No ☐ N/A ☐
	Yes ☐ No ☐ N/A ☐		Yes ☐ No ☐ N/A ☐
	Yes ☐ No ☐ N/A ☐		Yes ☐ No ☐ N/A ☐
	Yes ☐ No ☐ N/A ☐		Yes ☐ No ☐ N/A ☐
	Yes ☐ No ☐ N/A ☐		Yes ☐ No ☐ N/A ☐
	Yes ☐ No ☐ N/A ☐		Yes ☐ No ☐ N/A ☐
	Yes ☐ No ☐ N/A ☐		Yes ☐ No ☐ N/A ☐

Please supply more detailed information about your charge accounts, contracts, or other financial liabilities.	
Name of Firm	Address

Financial Continued

Have you ever filed for or declared bankruptcy or filed for the Wage Earner's Plan?	Yes ☐ No ☐
If "Yes," please give details (include when, where, why). Include a copy of all court related papers.	
Have any of your bills ever been turned over to a collection agency?	Yes ☐ No ☐
If "Yes," please give details (include when, firms involved, circumstances).	
Have you ever had purchased goods repossessed (taken back)?	Yes ☐ No ☐
If "Yes," please give details (include when, firms involved, circumstances).	
Have you ever had your wages garnished?	Yes ☐ No ☐
If "Yes," please give details (include when, where, and why).	

Financial Continued

Have you ever been delinquent on income or other tax payments?	Yes ☐ No ☐
If "Yes", please give details (include when, where, and why)	

Have you ever been delinquent on child support payments?	Yes ☐ No ☐ N/A ☐
If "Yes," please give details (include when, where, and why).	

Legal

Have you ever been charged with a violation of law, arrested, or issued a defendants summons for any offense (excluding traffic citations)?	Yes ☐ No ☐

If "Yes", please give details (include when, where, and why)

Date	Police Agency	Charge	Type	Disposition
			Felony ☐ Misdemeanor ☐	

Explanation:

Date	Police Agency	Charge	Type	Disposition
			Felony ☐ Misdemeanor ☐	

Explanation:

Legal Continued

Date	Police Agency	Charge	Type	Disposition
			Felony ☐ Misdemeanor ☐	

Explanation:

Date	Police Agency	Charge	Type	Disposition
			Felony ☐ Misdemeanor ☐	

Explanation:

Have you ever committed an illegal act or done anything that would have been considered unlawful if caught?	Yes ☐ No ☐

Legal Continued

Have you ever been charged or convicted of a domestic assault type offense?	Yes ☐ No ☐
If "Yes," please give details (include when, where and why).	
Have you or your spouse ever been involved as a plaintiff or defendant in any civil court action?	Yes ☐ No ☐
If "Yes," please give details (include when, where, location of court and circumstances).	
Have you ever obtained a criminal warrant for any person?	Yes ☐ No ☐
If "Yes," please give details (include when, where, name and location of court, and circumstances). Note: Do **not** include cases if you are/were a law enforcement officer.	
Are you now or have you ever been a member of any organization, group of individuals, movement or association that:	
Advocates denying other individuals their equal civil rights or liberties?	Yes ☐ No ☐
Advocates the overthrow of our constitutional form of government by force or violence?	Yes ☐ No ☐
Has conducted or been involved in any illegal activity?	Yes ☐ No ☐
If "Yes" was given to any of the previous three (3) questions, please list the organization and details below.	

Motor Vehicle

Driver's License Number	Name under which license was granted	Exp. Date (dd/mm/yy)	State

Please list other states where you have been licensed to operate a motor vehicle and the name under which the license was issued	Name	Operators License #	State

Have you ever been refused a driver's license by any state?	Yes ☐ No ☐

If "Yes," please give details (include when, where, why).

Rhode Island law requires that operators and owners of motor vehicles be covered by automobile liability insurance. Please list the current liability insurance information for your vehicle(s):

Make	Year (yy)	Insurance Company	Address	Policy Number	Exp. Date (mm/yy)

Have you ever been refused insurance for any reason other than failure to pay a premium?	Yes ☐ No ☐

If "Yes," please explain (include company name and address, date and reason).

Have you ever been issued a traffic citation (excluding parking citations)?	Yes ☐ No ☐ N/A ☐

If "Yes," please list all traffic citations (exclude parking citations) you have received.

Nature of violation	Location (City/State)	Date (mm/yy)	Disposition
			Guilty ☐ Not Guilty ☐ Driving School ☐
			Guilty ☐ Not Guilty ☐ Driving School ☐
			Guilty ☐ Not Guilty ☐ Driving School ☐
			Guilty ☐ Not Guilty ☐ Driving School ☐
			Guilty ☐ Not Guilty ☐ Driving School ☐
			Guilty ☐ Not Guilty ☐ Driving School ☐
			Guilty ☐ Not Guilty ☐ Driving School ☐
			Guilty ☐ Not Guilty ☐ Driving School ☐
			Guilty ☐ Not Guilty ☐ Driving School ☐

Motor Vehicle Continued

Have you ever been involved as a driver in a motor vehicle accident?	Yes ☐ No ☐

If "Yes," give details for each accident.

Date (mm/yy)	Location (City/State)	Police Investigation	Police Department	Type
		Yes ☐ No ☐		Injury ☐ Non-injury ☐
		Yes ☐ No ☐		Injury ☐ Non-injury ☐
		Yes ☐ No ☐		Injury ☐ Non-injury ☐
		Yes ☐ No ☐		Injury ☐ Non-injury ☐
		Yes ☐ No ☐		Injury ☐ Non-injury ☐

Has your license ever been suspended or revoked by Rhode Island or any other state?	Yes ☐ No ☐

If "Yes," please give details (include when, where, and why).

Have you ever been charged or convicted of a DUI related offense?	Yes ☐ No ☐

If "Yes," please give details (include when, where, and why).

General Info.

Are you a citizen of the United States?	Yes ☐ No ☐
Are you legally eligible to work in the United States?	Yes ☐ No ☐
If you are successful in gaining an appointment to this Department, do you expect to engage in any other gainful occupation?	Yes ☐ No ☐

If "Yes," please explain.

General Info. Continued

Are you currently using any illegal drugs, inclusive of marijuana?	Yes ☐ No ☐
If "Yes," please explain.	
Have you ever used any illegal drugs, inclusive of marijuana?	Yes ☐ No ☐
If "Yes," please explain.	
Have you ever purchased, transported, and/or sold any illegal drugs, inclusive of marijuana?	Yes ☐ No ☐
If "Yes," please explain.	
Have you ever manufactured or stored any illegal drugs, inclusive of marijuana?	Yes ☐ No ☐
If "Yes," please explain.	

General Info. Continued

Have you ever applied for a permit to carry a concealed weapon?	Yes ☐ No ☐

If "Yes", please provide the following information:

Permit Granted?	Type of Weapon	Date (mm/yy)	Law Enforcement Agency
Yes ☐ No ☐			
Purpose:			

Have you ever applied for employment with another law enforcement agency?	Yes ☐ No ☐

If "Yes", please provide the following information:

Agency Name (City and State)	Position	Date (mm/yy)	Disposition/Status

Have you ever applied for employment with this department?	Yes ☐ No ☐

If "Yes", list below:

Position	Date (mm/yy)	Disposition

Are you acquainted with any members of this Department?	Yes ☐ No ☐

If "Yes," please list.

Have you ever participated in an internship program with a Law Enforcement Agency?	Yes ☐ No ☐

If "Yes", please fill in.

College/University Affiliation	Law Enforcement Agency	Dates of participation (mm/yy)	
		To	From

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Employment

Beginning with your most current employment, please list in descending order all jobs (including part-time, temporary, and voluntary positions) you have held. (For the purposes of this employment history report, voluntary work should be included as employment). Please indicate the nature of the activity, i.e., full-time, part-time, or voluntary. If you have had intervening periods of military service or unemployment, please list those periods in sequence in the spaces provided.

Dates of Employment		Name and Address of Employer	Phone number
From (mm/yy)	To (mm/yy)		
Full-time ☐ Part-time ☐ Voluntary ☐ Unemployed ☐ Military ☐		Title	Name/Phone number of Supervisor
Duties/Responsibilities			Names of Co-Workers
Your Name if Different:			Salary:
N/A ☐			Starting: / Ending:
Termination Status			
Voluntary Resignation ☐ Resigned in lieu of being fired ☐ Fired ☐ Position Eliminated ☐			
Explain:			

Dates of Employment		Name and Address of Employer	Phone number
From (mm/yy)	To (mm/yy)		
Full-time ☐ Part-time ☐ Voluntary ☐ Unemployed ☐ Military ☐		Title	Name/Phone number of Supervisor
Duties/Responsibilities			Names of Co-Workers
Your Name if Different:			Salary:
N/A ☐			Starting: / Ending:
Termination Status			
Voluntary Resignation ☐ Resigned in lieu of being fired ☐ Fired ☐ Position Eliminated ☐			
Explain:			

Employment Continued

Dates of Employment		Name and Address of Employer	Phone number
From (mm/yy)	To (mm/yy)		
Full-time ☐ Part-time ☐ Voluntary ☐ Unemployed ☐ Military ☐		Title	Name/Phone number of Supervisor
Duties/Responsibilities			Names of Co-Workers
Your Name if Different:			Salary:
N/A ☐			Starting: / Ending:
Termination Status			
Voluntary Resignation ☐ Resigned in lieu of being fired ☐ Fired ☐ Position Eliminated ☐			
Explain:			

Dates of Employment		Name and Address of Employer	Phone number
From (mm/yy)	To (mm/yy)		
Full-time ☐ Part-time ☐ Voluntary ☐ Unemployed ☐ Military ☐		Title	Name/Phone number of Supervisor
Duties/Responsibilities			Names of Co-Workers
Your Name if Different:			Salary:
N/A ☐			Starting: / Ending:
Termination Status			
Voluntary Resignation ☐ Resigned in lieu of being fired ☐ Fired ☐ Position Eliminated ☐			
Explain:			

Employment Continued

Dates of Employment		Name and Address of Employer	Phone number
From (mm/yy)	To (mm/yy)		
Full-time ☐ Part-time ☐ Voluntary ☐ Unemployed ☐ Military ☐		Title	Name/Phone number of Supervisor
Duties/Responsibilities			Names of Co-Workers
Your Name if Different:			Salary:
N/A ☐			Starting: / Ending:
Termination Status			
Voluntary Resignation ☐ Resigned in lieu of being fired ☐ Fired ☐ Position Eliminated ☐			
Explain:			

Dates of Employment		Name and Address of Employer	Phone number
From (mm/yy)	To (mm/yy)		
Full-time ☐ Part-time ☐ Voluntary ☐ Unemployed ☐ Military ☐		Title	Name/Phone number of Supervisor
Duties/Responsibilities			Names of Co-Workers
Your Name if Different:			Salary:
N/A ☐			Starting: / Ending:
Termination Status			
Voluntary Resignation ☐ Resigned in lieu of being fired ☐ Fired ☐ Position Eliminated ☐			
Explain:			

Employment Continued

Dates of Employment		Name and Address of Employer	Phone number
From (mm/yy)	To (mm/yy)		
Full-time ☐ Part-time ☐ Voluntary ☐ Unemployed ☐ Military ☐		Title	Name/Phone number of Supervisor
Duties/Responsibilities			Names of Co-Workers
Your Name if Different:			Salary:
N/A ☐			Starting: / Ending:
Termination Status			
Voluntary Resignation ☐ Resigned in lieu of being fired ☐ Fired ☐ Position Eliminated ☐			
Explain:			

Dates of Employment		Name and Address of Employer	Phone number
From (mm/yy)	To (mm/yy)		
Full-time ☐ Part-time ☐ Voluntary ☐ Unemployed ☐ Military ☐		Title	Name/Phone number of Supervisor
Duties/Responsibilities			Names of Co-Workers
Your Name if Different:			Salary:
N/A ☐			Starting: / Ending:
Termination Status			
Voluntary Resignation ☐ Resigned in lieu of being fired ☐ Fired ☐ Position Eliminated ☐			
Explain:			

Employment Continued

Would any problems result if your present employer were contacted during the course of the background investigation?	Yes ☐ No ☐
If "Yes," please explain why.	
When should contact be made?	
If you have had no prior employment, please explain.	N/A ☐
Have you ever been disciplined, suspended, or otherwise received punitive actions at a current or former place of employment?	Yes ☐ No ☐
If "Yes," please explain why.	
Are you willing to work any type of shift associated with the position for which you have applied?	Yes ☐ No ☐
If "No," please explain why.	
Have you ever been fired, asked to resign, or resigned because you believed you would be fired from a job?	Yes ☐ No ☐
If "Yes," please give details (include when, where and circumstances).	

References

Please provide 3 professional references **NOT** related to you

Reference 1

Name:	Last	First		
Address:	Street Address			
	City	State	Zip Code	
Phone Number:				
E-Mail Address:				

Reference 2

Name:	Last	First		
Address:	Street Address			
	City	State	Zip Code	
Phone Number:				
E-Mail Address:				

Reference 3

Name:	Last	First		
Address:	Street Address			
	City	State	Zip Code	
Phone Number:				
E-Mail Address:				

CONSENT TO RELEASE

The statements made by me in my application for employment with the Town of Johnston are true and complete to the best of my knowledge. I understand that any willful misstatements or material omissions in the aforementioned applications will be sufficient cause to disqualify me from employment consideration with the Town of Johnston. If such misstatements or omissions are found after employment, it will be considered grounds for dismissal. I understand that the completed application, background investigation pre-screening packet and any materials submitted with it are the property of the Town of Johnston and will not be returned regardless if I am offered employment. I understand that any offer of employment is contingent upon my ability to produce documentation required by the Immigration and Naturalization Service documenting eligibility, if necessary, for employment.

I authorize the release of any and all education and credit related information that the Town of Johnston may request or any records pertaining to past or present employment, which may now exist or exist in the future.

Signature _____ Date Signed _____

PLEASE FILL OUT ALL HIGHLIGHTED PORTIONS OF THE FOLLOWING PAPERWORK

JOHNSTON POLICE DEPARTMENT

Chief of Police, Mark A. Vieira

General Authorization for Release of Information

I, _____, do hereby authorize a review and full disclosure of all records, or any part thereof, concerning myself, by and to duly authorized agents of the Johnston Police Department and the Rhode Island Municipal Police Academy, whether the said records are of a public, private, or confidential nature.

The intent of this authorization is to give my consent for full and complete disclosure of Casino Gaming records; records of educational institutions; financial or credit institutions, including records of deposits, withdrawals and balances of checking and savings accounts, and loans, and also the records of commercial or retail credit agencies, including credit reports and ratings; medical and psychiatric treatment and consultation, including hospitals, clinics, private practitioners; the U.S. Veteran's Administration; the United States military; public utility companies; employment and pre-employment records, including background reports, efficiency ratings, complaints or grievances filed by or against me, and salary records; housing records; real and personal property tax statements and records; other financial statements and records wherever filed; records of complaint, arrest, trial and/or convictions for alleged or actual violations of law, including criminal and/or traffic records; records of complaints in any civil proceeding made in any case in which I presently have, or have had any interest.

I reiterate and emphasize that the intent of this authorization is to provide full and free access to the background and history of my personal life, for the specific purpose of pursuing a background investigation, which may provide pertinent data and/or information for the Johnston Police Department and the Rhode Island Municipal Police Academy to consider in determining my suitability for employment by that department.

It is my specific intent to provide access to personal information, however personal or confidential it may appear to be, and the sources of information specifically enumerated above is not intended to deny access to any records not specifically identified herein.
I understand that any information obtained by a personal history background investigation, which is developed directly or indirectly, in whole or in part pursuant to this release authorization will be considered in determining my suitability for employment by the Johnston Police Department and the Rhode Island Municipal Police Academy. I have had explained to me, and I fully understand that refusal to grant this authorization will not, of itself, constitute a basis for rejection of my application.

To the custodian of the records discussed herein, I hereby authorize you to release information to the bearer of this *Authorization for Release of Information*. I consider a copy of the *Authorization for Release of Information* to be as valid as the original even though a copy does not have my original signature.

I hereby release to the Johnston Police Department and the Rhode Island Municipal Police Academy and its agents and anyone who gives written or oral information about me to the Johnston Police Department from any claims of liability or damages which may occur as a result of the background investigation. This release of liability also extends to my heirs, executors, assigns and representatives.

Print Name: _____

Signature: _____

Address: _____
(Street Address) (City/Town) (State) (Zip Code)

Date of Birth: _____ Soc. Sec. Number: _____

Witness: _____

RHODE ISLAND DEPARTMENT OF PUBLIC SAFETY
Municipal Police Training Academy

Community College of Rhode Island — Flanagan Campus
1762 Louisquisset Pike, Lincoln, RI 02865-4585
Telephone: (401) 205-2500 — Fax: (401) 205-2501

Colonel Darnell S. Weaver
Superintendent, Rhode Island State Police
Director, Department of Public Safety

Lieutenant Christopher J. Zarrella
Executive Director
Municipal Police Training Academy

General Authorization for Release of Information

I, _____, do hereby authorize a review and full disclosure of all records, or any part thereof, concerning myself, by and to duly authorized agents of the _____Johnston_____ Police Department and the Rhode Island Municipal Police Academy, whether the said records are of a public, private, or confidential nature.

The intent of this authorization is to give my consent for full and complete disclosure of Casino Gaming records; records of educational institutions; financial or credit institutions, including records of deposits, withdrawals and balances of checking and savings accounts, and loans, and also the records of commercial or retail credit agencies, including credit reports and ratings; medical and psychiatric treatment and consultation, including hospitals, clinics, private practitioners; the U.S. Veteran's Administration; the United States military; public utility companies; employment and pre-employment records, including background reports, efficiency ratings, complaints or grievances filed by or against me, and salary records; housing records; real and personal property tax statements and records; other financial statements and records wherever filed; records of complaint, arrest, trial and/or convictions for alleged or actual violations of law, including criminal and/or traffic records; records of complaints in any civil proceeding made in any case in which I presently have, or have had any interest.

I reiterate and emphasize that the intent of this authorization is to provide full and free access to the background and history of my personal life, for the specific purpose of pursuing a background investigation, which may provide pertinent data and/or information for the _____Johnston_____Police Department and the Rhode Island Municipal Police Academy to consider in determining my suitability for employment by that department.

It is my specific intent to provide access to personal information, however personal or confidential it may appear to be, and the sources of information specifically enumerated above is not intended to deny access to any records not specifically identified herein.

I understand that any information obtained by a personal history background investigation, which is developed directly or indirectly, in whole or in part pursuant to this release authorization will be considered in determining my suitability for employment by the _____Johnston_____ Police Department and the Rhode Island Municipal Police Academy. I have had explained to me, and I fully understand that refusal to grant this authorization will not, of itself, constitute a basis for rejection of my application.

To the custodian of the records discussed herein, I hereby authorize you to release information to the bearer of this *Authorization for Release of Information.* I consider a copy of the *Authorization for Release of Information* to be as valid as the original even though a copy does not have my original signature.

I hereby release to the _____Johnston_____ Police Department and the Rhode Island Municipal Police Academy and its agents and anyone who gives written or oral information about me to the _____Johnston_____ Police Department from any claims of liability or damages which may occur as a result of the background investigation. This release of liability also extends to my heirs, executors, assigns and representatives.

Print Name: _____

Signature: _____

Address: _____

Date of Birth: _____Soc. Sec. Number: _____

Witness: _____

Chief of Police, Mark A. Vieira

Mental Health
Authorization for Release of Information

I, _____, do hereby authorize a review and full disclosure of all records, or any part thereof, concerning myself, by and to duly authorized agents of the Johnston Police Department, whether the said records are of a public, private, or confidential nature.

The intent of this authorization is to give my consent for full and complete disclosure of the records from _____ (name of institution) regarding medical and psychiatric treatment and consultation, including records of hospitals, clinics and private practitioners operating within or in association with said _____ (name of institution).

I reiterate and emphasize that the intent of this authorization is to provide full and free access to the background and history of my personal life, for the specific purpose of pursuing a background investigation, which may provide pertinent data and/or information for the Johnston Police Department to consider in determining my suitability for employment by that department.

It is my specific intent to provide access to personal information, however personal or confidential it may appear to be, and the sources of information specifically enumerated above is not intended to deny access to any records not specifically identified herein.

I understand that any information obtained by a personal history background investigation, which is developed directly or indirectly, in whole or in part, pursuant to this release authorization will be considered in determining my suitability for employment by the Johnston Police Department. I have had explained to me, and I fully understand, that refusal to grant this authorization will not, of itself, constitute a basis for rejection of my application.

To the custodian of the records discussed herein, I hereby authorize you to release information to the bearer of this *Authorization for Release of Information.* I consider a copy of the *Authorization for Release of Information* to be as valid as the original even though a copy does not have my original signature.

I hereby release to the Johnston Police Department and its agents and anyone who gives written or oral information about me to the Johnston Police Department from any claims of liability or damages which may occur as a result of the background investigation. This release of liability also extends to my heirs, executors, assigns and representatives.

Print Name: _____

Signature: _____

Address: _____
(Street Address) (City/Town) (State) (Zip Code)

Date of Birth: _____ Soc. Sec. Number: _____

Witness: _____

RHODE ISLAND DEPARTMENT OF PUBLIC SAFETY
Municipal Police Training Academy

Community College of Rhode Island — Flanagan Campus
1762 Louisquisset Pike, Lincoln, RI 02865-4585
Telephone: (401) 205-2500 — Fax: (401) 205-2501

Colonel Darnell S. Weaver
Superintendent, Rhode Island State Police
Director, Department of Public Safety

Lieutenant Christopher J. Zarrella
Executive Director
Municipal Police Training Academy

Mental Health

Authorization for Release of Information

I, _____, do hereby authorize a review and full disclosure of all records, or any part thereof, concerning myself, by and to duly authorized agents of the Johnston Police Department, whether the said records are of a public, private, or confidential nature.

The intent of this authorization is to give my consent for full and complete disclosure of the records from _____ (name of institution) regarding medical and psychiatric treatment and consultation, including records of hospitals, clinics and private practitioners operating within or in association with said _____ (name of institution).

I reiterate and emphasize that the intent of this authorization is to provide full and free access to the background and history of my personal life, for the specific purpose of pursuing a background investigation, which may provide pertinent data and/or information for the Johnston Police Department to consider in determining my suitability for employment by that department.

It is my specific intent to provide access to personal information, however personal or confidential it may appear to be, and the sources of information specifically enumerated above is not intended to deny access to any records not specifically identified herein.

I understand that any information obtained by a personal history background investigation, which is developed directly or indirectly, in whole or in part, pursuant to this release authorization will be considered in determining my suitability for employment by the Johnston Police Department. I have had explained to me, and I fully understand, that refusal to grant this authorization will not, of itself, constitute a basis for rejection of my application.

To the custodian of the records discussed herein, I hereby authorize you to release information to the bearer of this *Authorization for Release of Information.* I consider a copy of the *Authorization for Release of Information* to be as valid as the original even though a copy does not have my original signature.

I hereby release to the Johnston Police Department and its agents and anyone who gives written or oral information about me to the Johnston Police Department from any claims of liability or damages which may occur as a result of the background investigation. This release of liability also extends to my heirs, executors, assigns and representatives.

Print Name: _____

Signature: _____

Address: _____

Date of Birth: _____ Soc. Sec. Number: _____

Witness: _____

FULLER HOSPITAL
LEADING THE WAY IN BEHAVIORAL HEALTH

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Birth Date: _____
Maiden/Prior Names: _____ Current Phone #: _____
Current Address: _____ Last 4 of SS#: _____

To be released to or requested from:

☐ Self (address above)

☒ Johnston Police Department (401) 231-4210 ext. 3182 1651 Atwood Ave, Johnston, RI 02919
Agency/Organization Telephone Number Street Address

Justine Dutilly ~ Administrative Div. (401) 233-3314 Johnston RI 02919
Name / Attention to Fax Number City State Zip Code

Via (only when released to): ☒ Mail ☒ Fax ☐ Pick-up ☒ Email: jdutilly@johnstonpd.com
☐ Verbal Exchange of Information ONLY

I am requesting disclosure of my protected health information for the following purpose:

☐ Continuing Care ☐ Disability Determination ☐ Child Custody ☐ Personal Use
☐ Academic ☐ Legal Investigation ☐ Billing/Insurance ☒ Other: Pre-Employment Investigation

Dates of Service Requested: any/all

☒ **I authorize the release of the following information <u>including</u> all records that include any substance use disorder and/or substance use disorder treatment records, or**

☐ **I authorize the release of the following information <u>excluding</u> all records that include any substance use disorder and/or substance use disorder treatment records,**

Only the information and records indicated below (check all that apply and /or specific if "Other is checked):

☒ Continuity/Transition of Care Packet
☒ Psychiatric Evaluation
☒ History and Physical
☒ Discharge Summary
☒ Progress Notes
☒ Physician Orders
☒ Lab/Diagnostic Reports
☒ HIV Test Results and AIDS Treatment Records
☒ Other: mental health/substance use

This authorization will expire on ____/____/20____. (If not indicated, authorization will expire <u>one year</u> from signature date)

This form must be completed in full before signing:

_____ _____ _____
Patient's signature (required for ages 18 and older) Parent/Legal Guardian signature (if applicable) Relationship to Patient

_____ _____
Witness signature/Credentials Date Signed

This authorization is intended to allow Fuller Hospital to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure.

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. Your right to inspect and receive a copy of the information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request. _____ _____
Revocation Signature Date/Time

BUTLER HOSPITAL
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ _____ **Date of Birth:** _____
(Please Print Full Name)

I authorize the use and/or disclosure of the above-named individual's health information as described in this authorization. I, therefore, authorize Butler Hospital, 345 Blackstone Boulevard, Providence, Rhode Island 02906 to:

☑ **Release to:** ☑ **Request from:**

Agency Name (If Applicable): **Johnston Police Department**

Name (First and Last): **Justine Dutilly ~ Administrative Division**

Street Address: **1651 Atwood Avenue**

City/State/Zip Code: **Johnston, RI 02919**

This authorization will have a duration of consent no longer than 90 days after the date of this form or for the duration of treatment should the duration of treatment be longer than 90 days. Information may be released by the following methods:

☐ Telephone/Verbal Phone #: **(401) 231-4210**
☑ Photocopies
☑ FAX Fax#: **(401) 233-3314**
E-Mail: **jdutilly@johnstonpd.com**

Information to be released includes:

☑ Discharge Summary ☑ Psychiatric Exam ☑ Treatment Plan ☑ Progress Notes
☑ Psychological Test ☑ History and Physical ☑ Laboratory Data Including HIV
☑ Other (Please be specific): **any/all**
For Dates of Service: _____

☐ **DO NOT RELEASE**: ☐ HIV Test ☐ *Other (Specific):* _____

The purposes of the request are described below (each purpose must be listed):

pre-employment background

☑ At the request of the individual for his/her own purposes.

I understand that the information in the health record may relate to treatment for alcohol and drug abuse and/or the results of diagnostic tests used to determine if the individual is infected by the human immunodeficiency virus (HIV). Unless I have indicated otherwise above, I specifically authorize the release of this information.

I understand that I have the right to revoke (cancel) this authorization at any time. I understand that to revoke this authorization, I must contact the Director of Medical Records at Butler Hospital and will be required to put my revocation (cancellation) in writing. I understand that the revocation will not be effective until it is received, and it will not apply to information that has already been released in response to this authorization. I also understand that a revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that signing this authorization is voluntary and that Butler Hospital will provide treatment and pursue payment for service regardless of whether I sign this authorization.

I understand that if I authorize Butler Hospital to disclose information, the recipient of the information might disclose it to others, and that any information disclosed by Butler Hospital may no longer be protected by the federal rule on privacy of medical records.

_____ _____ _____ _____
Patient Signature or authorized Representative | Date | Witness Signature | Date

_____ _____ Printed Name of Authorized Representative
Relationship

☐ **Send Aftercare Information:**
Patient's Appointment **Date:** _____ **Time:** _____

☐ **SSend**

10136

Care New England

FOR INPATIENTS: AFFIX PATIENT LABEL OR WRITE IN BOTH PATIENT NAME & MR NUMBER

FOR OUTPATIENTS: WRITE IN BOTH PT NAME & DOB

PATIENT NAME: _____

DOB OR MR #: _____

AUTHORIZATION TO RELEASE HEALTH INFORMATION

10136 (5-2021)

1. Patient name: _____ _____ ("Patient") Date of Birth: _____ Telephone: _____

   Address: _____ (Street) _____ (City) _____ (State) _____ (Zip) Med. Rec. #: _____

2. The undersigned hereby authorizes the following CNE Provider _____ (insert Hospital/Facility/Physician name) (the "**Provider**")

   Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

   Telephone: _____ _____ Fax: _____ _____

   ☑ to release/disclose to the Individual and/or entity named in Section 3 ("**Recipient**")
   AND/OR
   ☐ to request/receive from the Individual and/or entity named in Section 3 ("**Disclosing Party**")
   the protected health information ("**Health Information**") specified in Section 4

3. Recipient or Disclosing Party: Johnston Police Department ~ Attn. Justine Dutilly _____ (Insert Individual/Entity Name)

   Telephone: (401) 231-4210 _____ Fax Number (if Health Information is to be faxed): (401) 233-3314

   Address: 1651 Atwood Avenue, Johsnton, RI 02919 (Street) (City) (State) (Zip) E-Mail: jdutilly@johnstonpd.com

4. Please check one or more types of Health Information to be released/requested:

☑ Allergies	☑ Laboratory Results	☑ Operative Report
☑ Immunization Records	☑ X-Ray/Imaging Results	☑ Psychiatric Exam
☑ Emergency Dept. Records**	☑ History & Physical	☑ Psychological Tests
☑ Registration Record	☑ Progress Notes	☑ Treatment Plan(s)
☑ Discharge Summary	☑ Consultation Reports	☑ Entire Record

   OTHER (Please specify): _____

   An authorization for Emergency Department Records may include any of the above listed Health Information records.

5. Time frame for which the Health Information authorized in Section 4 above should be released/requested:
   For the period from _____ (insert start date) through _____ (insert end date);
   OR ALL DATES OF TREATMENT _____ (Please Initial)

6. The undersigned acknowledges, agrees, and understands that unless specifically limited below, any Health Information released may include mental health treatment information, alcohol and substance abuse treatment information, STDs and/or HIV/AIDS-related information.
   DO NOT RELEASE THE FOLLOWING HEALTH INFORMATION (Please specify): _____

7. This authorization is being requested by the undersigned for the following purpose(s) (initial all that apply)
   _____ Medical Care _____ Legal _____ Insurance _____ Personal
   Other (Please describe): pre-employment background

8. The undersigned acknowledges and understands each of the following:
   - authorizing the release of the Patient's Health Information is voluntary;
   - refusal to sign this authorization does not affect the Patient's treatment, payment of claims, health plan enrollment or eligibility for benefits;
   - this authorization may be revoked at any time upon written request to the Provider's privacy officer or health information department except to the extent that release of Patient's Health Information has already occurred in reliance on this authorization;
   - unless previously revoked, this authorization will automatically expire TWELVE (12) months from the date of signature below unless a shorter timeframe specified here _____ (enter date authorization will expire);
   - ***any Information released to the Recipient may be re-disclosed and may no longer be protected by federal or state privacy and or confidentiality laws.***

THE UNDERSIGNED (1) HAS READ AND UNDERSTANDS THIS AUTHORIZATION; (2) HAS HAD ANY QUESTIONS WITH RESPECT TO THIS AUTHORIZATION EXPLAINED TO HIS/HER SATISFACTION; (3) IS AUTHORIZED TO SIGN THIS AUTHORIZATION INDIVIDUALLY AS THE PATIENT OR AS THE PATIENT'S LEGAL REPRESENTATIVE; AND (4) HEREBY EXPRESSLY AND VOLUNTARILY AUTHORIZES THE RELEASE/ REQUEST OF THE PATIENT'S HEALTH INFORMATION AS SPECIFIED ABOVE.

_____ _____ _____ _____ _____ _____

Signature of Patient or Legal Representative of Patient — Date/Time

_____ _____ _____ _____ _____ _____

PRINT name of Patient or Legal Representative of Patient — Relationship to Patient or Authority to Act for Patient

THIS AUTHORIZATION SHALL BE INVALID UNLESS ALL APPLICABLE SECTIONS ARE COMPLETE

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILTIES AND HOSPITALS

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

1. I, _____
(Print first name, last name & date of birth of the Individual for whom information is being requested)

2. I hereby authorize the following information to be released: (check all that apply)

☑ Physician Orders	☑ Treatment Plan	☑ Continuity of Care Forms	☑ Therapy Reports
☑ Progress Notes	☑ Social Service Records	☑ Inter-Agency Referral(s)	☑ Financial Records
☑ Discharge Summary	☑ Laboratory Reports	☑ School/Edu. Records	☑ Billing Requests/Reports
☑ History and Physical	☑ Consultation Reports	☑ Psychology Records	☑ Vocational Records

☑ Other (please be specific) _____

3. I hereby authorize the following information <u>not</u> to be released*: (check all that apply)

☑ Substance Abuse/dependency/diagnosis/treatment/referral (42 CFR) ☑ Mental Health/diagnosis/treatment/referral
☑ HIV Test results /AIDS related information/(ARC) diagnosis and/or treatment
☑ Diagnoses and/or treatment relating to other communicable diseases

* This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2.

4. My information is to be obtained from:

ELEANOR SLATER HOSPITAL
(Name of Organization)
P.O. BOX 8269
(Address)
CRANSTON RI,02920
(City/State/Zip)
Sharon Maynard 401-462-2316 &
(Contact Name and Telephone Number)
THERESA CLARK 401-462-6790

5. My information is to be released to:

Johnston Police Department
(Name of Organization)
(Address) 1651 Atwood Avenue
Johnston, RI 02919
(City/State/Zip)
Justine Dutilly (401) 757-3182 or (401) 231-4210
(Contact Name and Telephone Number)
E-Mail: jdutilly@johnstonpd.com

Method of Communication:
☐ Verbal ☑ Printed Materials

6. This authorization is for information applicable to the time period specified below:

From:_____ To:_____

7. Pre-Employment Background
(Indicate the specific purpose or need for this release of information)

8. Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the federal privacy regulations. BHDDH may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of an authorization. I understand that I have the right to revoke this authorization in writing at anytime, and that the revocation will be effective except to the extent that the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) has already taken action in reliance on my authorization. I understand that if this authorization has not been revoked, it will expire in 90 days from the date of my signature. **My instructions to revoke my authorization should be directed to:**

_____
(Name and address of BHDDH Records person responsible for this request)

9. Signature of individual: _____ Date: _____

10. Signature of authorized representative _____ Relationship: _____

Print Name: _____ Date: _____

<u>For Office Use Only</u>: Information Released: Y N Date of release: _____
Staff Person Releasing Information: _____

McLean HOSPITAL
HARVARD MEDICAL SCHOOL AFFILIATE

Health Information Management
121 Inner Belt Road, Room 240, Somerville, MA 02143
Telephone 617.726.2361 Fax 617.726\.3661

3-Hole 5/16 4 1/4 c-to-c

AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION

Patient Name: _____ **Date of Birth:** _____

Specific information to be released:
- ☑ Verbal Information/Telephone Update
- ☑ Discharge/Treatment Summary
- ☑ Other *(specify)* any/all

Purpose:
- ☐ Treatment
- ☐ Financial
- ☐ *Personal
- ☑ *Other pre-employment background

☑ I hereby authorize the **following person or facility to release** the above information to McLean Hospital:

☑ I hereby authorize **McLean Hospital to release** the above information to the following person or facility:

To: ☐ Referring/Aftercare Clinician ☐ PCP ☑ Other

Name/Facility: Johnston Police Department

Address: 1651 Atwood Ave Johnston, RI 02919

Attn: Justine Dutilly Operations & Training Clerk

Phone: (401) 757-3182 Fax: (401) 233-3314

E-Mail: jdutilly@johnstonpd.com

Specific information to be released:
- ☑ Verbal Information/Telephone Update
- ☑ Discharge/Treatment Summary
- ☑ Other *(specify)* any/all

Purpose:
- ☐ Treatment
- ☐ Financial
- ☐ *Personal
- ☑ *Other pre-employment background

☑ I hereby authorize the **following person or facility to release** the above information to McLean Hospital:

☑ I hereby authorize **McLean Hospital to release** the above information to the following person or facility:

To: ☐ Referring/Aftercare Clinician ☐ PCP ☑ Other

Name/Facility: Johnston Police Department

Address: 1651 Atwood Ave Johnston, RI 02919

Attn: Justine Dutilly Operations & Training Clerk

Phone: (401) 757-3182 Fax: (401) 233-3314

E-Mail: jdutilly@johnstonpd.com

*Copying fees may apply

Information should be sent to: McLean Hospital, 115 Mill Street, Belmont, MA 02478-9106 Fax: (617) 855-2727

Attention: (*Name of McLean staff member who should receive the information)* _____

Mental Health Information. I authorize disclosure of such information, including details of mental health diagnosis and/or treatment provided by a Psychiatrist, Psychologist, Licensed Mental Health Clinician, Advanced Practice Nurse, or Licensed Social Worker.

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the Director of Health Information Management. Authorization may be withdrawn except to the extent that action has already been taken in reliance on this authorization. If the authorization was obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy, even if authorization has been withdrawn.
- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected.
- Information released on this authorization, if redisclosed by the recipient, is no longer protected by McLean Hospital.
- This release will expire 180 days from the date below or as otherwise specified: _____.

YES *Please check yes for the following questions, to indicate if we may release information below (if it is in your medical record.)*

- ☑ **Alcohol and Drug Abuse Treatment.** To the extent that my medical record contains information regarding alcohol or drug treatment that is protected by Federal Regulation 42 CFR, Part 2.
- ☑ **HIV Information.** To the extent that my medical record contains information concerning HIV antibody and antigen testing that is protected by M.G.L. Ch.111 §70f.
- ☑ Details of Domestic Violence Victims' Counseling
- ☑ Details of Sexual Assault Counseling

Patient or Patient Representative: Please make sure that all appropriate sections above are completed before signing this authorization. Do *not* sign a blank authorization form.

_____ _____ _____

Signature of Patient (if 18 or older); *or* Parent (if patient is under 18); *or* Legal Guardian; or Health Care Agent *(circle one)*

Printed Name of Patient or Authorized Person

Date

HEALTH INFORMATION SERVICES
AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED INFORMATION

☑ **REQUEST COPIES OF MEDICAL RECORD** ☐ **REVIEW MEDICAL RECORD**

I do hereby authorize the following CharterCARE Health Partners affiliates entities (to include without limitation)

- ☐ Roger Williams Medical Center
- ☐ Roger Williams Medical Associates
- ☐ Elmhurst Extended Care Facility
- ☐ Elmhurst Health Associates
- ☐ St. Joseph Health Services
- ☐ Our Lady of Fatima Ancillary Services
- ☐ Southern New England Rehabilitation Center
- ☑ All

to release my protected health information, including copies of my medical record of care to the following person(s) or persons at the location/facility listed below for the purpose(s) as indicated:

Patient Name: _____ DOB: _____
(Last) (First) (M.I.)

Patient Address: _____
_____
_____

Patient Telephone (for contact): ( ) _____ work /home / cell

Email address: _____

Recipient

Johnston Police Department
Name
Attn: Justine Dutilly Administrative Div. Clerk
1651 Atwood Ave
Address
Johnston, RI 02919
City, State, Zip Code
Phone: (401) 757-3182 Fax: (401) 233-3314 E-Mail: jdutilly@johnstonpd.com

Purpose (*check the appropriate box*)

- ☐ Medical Care
- ☐ Legal Matter
- ☐ Insurance
- ☐ Personal
- ☑ Other (please specify) *

* **pre-employment background**

Concerning my treatment for the period of: **any/all**

PROTECTED HEALTH INFORMATION TO BE RELEASED ***(Please check the appropriate box(s) and provide dates):***

- ☐ Discharge Summary (dates) _____
- ☐ Operative Reports (dates) _____
- ☐ Outpatient Test Results (dates) _____
- ☐ X-Rays/Scan Reports (dates) _____
- ☐ Pathology Reports (dates) _____
- ☐ Emergency Room (dates) _____
- ☐ Lab Reports (dates) _____
- ☐ Other *(please specify)* _____

☐ Reports ☐ Films ☐ Billing _____

☑ Medical Record Abstract (*e.g. Discharge Summary, Consultations, History & Physical, Operative, Pathology, and Test Reports)*

Authorization for Release of
Specifically Protected Information

I request the release of the specific categories of information that I have *INITIALED* below:

_____ HIV test results (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.)
SPECIFY DATE(S): any/all
_____Records pertaining to Sexually-Transmitted Diseases
_____ Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2
(FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED OR WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.)

_____ Other(s): Please List _____

Confidential Details of:
_____ Psychotherapy (from a Psychiatrist, Psychologist, or Psychiatric Clinical Nurse Specialist)
(cannot be authorized in conjunction with non psychotherapy authorization)
_____ Other professional services of a licensed psychologist
_____ Social Work Counseling/Therapy
_____ Domestic Violence Victims' Counseling
_____ Sexual Assault Counseling

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the Director of Health Information Management.
- Authorization may be withdrawn except for the following:
  *To the extent that action has been taken in reliance on this statement
  *If the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy.
- I may refuse to sign this authorization.
- If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and no longer protected by this rule.
- I understand that even if I do not withdraw this consent that this statement shall expire in:
  (please check one):_____3 months _____6 months_____12 months _____Other
  (if no time is indicated authorization will expire in one year)

I have carefully read and understand the above, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Patient's Signature: _____Date:_____ Relationship, if not patient_____

Print Name: _____Witness:_____Date:_____

_____
Basis of Authority to act on behalf of the patient

TO BE COMPLETED BY OFFICE STAFF/FACILITY RELEASING INFORMATION:

Date___/___/____ ID Verified: Y / N # Pages (if) Given to Patient_____ Initials: _____

Type of Delivery: Email _____ Mail _____ Other_____

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPER WORK REDUCTION ACT INFORMATION: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless is displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read the instructions, gather the necessary facts and fill out this form. The execution of this form does not authorize the release of information other than that specifically described below.

The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if information needed to locate records for release is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10A7 "Patient Medical Record - VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify Veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Address of VA Health Care Facility)*

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

PATIENT'S MAILING ADDRESS (*including City, State and Zip Code*)

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Johnston Police Department ~ Administrative Division ~ Attn. Justine Dutilly
1651 Atwood Ave, Johnston, RI 02919
Phone: (401) 231-4210 | Direct Line: (401) 757-3182 | Fax: (401) 233-3314 | E-Mail: jdutilly@johnstonpd.com

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

☐ TREATMENT ☐ BENEFITS ☐ LEGAL ☑ EMPLOYMENT ☐ OTHER *(Please specify)* _____

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

☑ HEALTH SUMMARY *(Prior 2 Years)*

☑ INPATIENT DISCHARGE SUMMARY *(Dates)*: _____

☑ PROGRESS NOTES:

- ☐ SPECIFIC CLINICS *(Name & Date Range)*: _____
- ☐ SPECIFIC PROVIDERS *(Name & Date Range)*: _____
- ☐ DATE RANGE: _____

☑ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: _____

☑ LAB RESULTS:

- ☐ SPECIFIC TESTS *(Name & Date)*: _____
- ☐ DATE RANGE: _____

☑ RADIOLOGY REPORTS *(Name & Date)*: _____

☑ LIST OF ACTIVE MEDICATIONS: _____

☑ FLU VACCINATION *(Dose, Lot Number, Date & Location)*: _____

_____

☑ OTHER *(Describe)*: _____

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.

☑ DRUG ABUSE ☑ ALCOHOLISM OR ALCOHOL ABUSE ☑ SICKLE CELL ANEMIA

☑ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

EXPIRATION: Without my express revocation, the authorization will automatically expire *(select one of the following)*:

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

☐ ON *(mm/dd/yyyy)* _____ *(enter a future date other than date signed by patient)*

☑ UNDER THE FOLLOWING CONDITION(S): one year

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
LEGAL REPRESENTATIVE SIGNATURE *(if applicable) (Sign in ink)*	DATE *(mm/dd/yyyy)*
PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED *(mm/dd/yyyy)*	RELEASED BY:

Form **4506T-EZ**
(March 2019)
Department of the Treasury
Internal Revenue Service

Short Form Request for Individual Tax Return Transcript

► **Request may not be processed if the form is incomplete or illegible.**
► **For more information about Form 4506T-EZ, visit *www.irs.gov/form4506tez*.**

OMB No. 1545-2154

Tip. Use Form 4506T-EZ to order a 1040 series tax return transcript free of charge, or you can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get Transcript of Your Tax Records" under "Tools" or call 1-800-908-9946.

1a Name shown on tax return. If a joint return, enter the name shown first.

1b **First social security number or individual taxpayer identification number on tax return**

2a If a joint return, enter spouse's name shown on tax return.

2b **Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5a If the transcript is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax information.

Third party name: Johnston Police Department
Attn: Administrative Clerk Justine Dutilly

Telephone number (401) 757-3182 or (401) 231-4210
Fax number (401) 233-3314
E-Mail jdutilly@johnstonpd.com

Address (including apt., room, or suite no.), city, state, and ZIP code

1651 Atwood Avenue
Johnston, RI 02919

5b Customer file number (if applicable) (see instructions)

Caution. If the tax transcript is being mailed to a third party, ensure that you have filled in line 6 before signing. Sign and date the form once you have filled in this line. Completing this step helps to protect your privacy. Once the IRS discloses your IRS transcript to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your transcript information, you can specify this limitation in your written agreement with the third party.

6. Year(s) requested. Enter the year(s) of the return transcript you are requesting (for example, "2008"). Most requests will be processed within 10 business days.

2021 | 2020 | 2019 |

Note. *If the IRS is unable to locate a return that matches the taxpayer identity information provided above, or if IRS records indicate that the return has not been filed, the IRS will notify you or the third party that it was unable to locate a return, or that a return was not filed, whichever is applicable.*

Caution. Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am the taxpayer whose name is shown on either line 1a or 2a. If the request applies to a joint return, **either** spouse must sign. **Note:** This form must be received by IRS within 120 days of the signature date.

☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-T.** See instructions.

Sign Here

► **Signature** (see instructions) | Date | Phone number of taxpayer on line 1a or 2a

► **Spouse's signature** | Date

Form **8821**

(Rev. January 2021)

Department of the Treasury
Internal Revenue Service

Tax Information Authorization

▶ **Go to *www.irs.gov/Form8821* for instructions and the latest information.**
▶ **Don't sign this form unless all applicable lines have been completed.**
▶ **Don't use Form 8821 to request copies of your tax returns or to authorize someone to represent you. See instructions.**

OMB No. 1545-1165

For IRS Use Only
Received by:
Name
Telephone
Function
Date

1 Taxpayer information. Taxpayer must sign and date this form on line 6.

Taxpayer name and address	Taxpayer identification number(s)	
	Daytime telephone number	Plan number (if applicable)

2 Designee(s). If you wish to name more than two designees, attach a list to this form. **Check here if a list of additional designees is attached ▶** ☐

Name and address **Johnston Police Department** **Attn: Justine Dutilly ~ Administrative Division** **1651 Atwood Ave., Johnston, RI 02919** **E-Mail: jdutilly@johnston pd.com** **Check if to be sent copies of notices and communications** ☐	CAF No. PTIN Telephone No. **(401) 757-3182 or (401) 231-4210** Fax No. **(401) 233-3314** Check if new: Address ☐ Telephone No. ☐ Fax No. ☐
Name and address **Check if to be sent copies of notices and communications** ☐	CAF No. PTIN Telephone No. Fax No. Check if new: Address ☐ Telephone No. ☐ Fax No. ☐

3 Tax information. Each designee is authorized to inspect and/or receive confidential tax information for the type of tax, forms, periods, and specific matters you list below. See the line 3 instructions.

☑ By checking here, I authorize access to my IRS records via an Intermediate Service Provider.

(a) Type of Tax Information (Income, Employment, Payroll, Excise, Estate, Gift, Civil Penalty, Sec. 4980H Payments, etc.)	(b) Tax Form Number (1040, 941, 720, etc.)	(c) Year(s) or Period(s)	(d) Specific Tax Matters
Tax Return	**1040**	**2021, 2020 & 2019**	**Pre-Employment Background**

4 Specific use not recorded on the Centralized Authorization File (CAF). If the tax information authorization is for a specific use not recorded on CAF, check this box. See the instructions. If you check this box, skip line 5 . . . . . ▶ ☑

5 Retention/revocation of prior tax information authorizations. If the line 4 box is checked, skip this line. If the line 4 box isn't checked, the IRS will automatically revoke all prior tax information authorizations on file unless you check the line 5 box and **attach a copy** of the tax information authorization(s) that you want to retain . . . . . ▶ ☐

To revoke a prior tax information authorization(s) without submitting a new authorization, see the line 5 instructions.

6 Taxpayer signature. If signed by a corporate officer, partner, guardian, partnership representative (or designated individual, if applicable), executor, receiver, administrator, trustee, or individual other than the taxpayer, I certify that I have the legal authority to execute this form with respect to the tax matters and tax periods shown on line 3 above.

▶ IF NOT COMPLETED, SIGNED, AND DATED, THIS TAX INFORMATION AUTHORIZATION WILL BE RETURNED.

▶ DON'T SIGN THIS FORM IF IT IS BLANK OR INCOMPLETE.

Signature | Date

Print Name | Title (if applicable)