STATE OF WISCONSIN
DEPARTMENT OF ADMINISTRATION
DIVISION OF PERSONNEL MANAGEMENT
DOA-5202 R (6/2020)

CONFIDENTIAL INFORMATION/RECORD(S) RELEASE AUTHORIZATION

INDIVIDUAL/AGENCY/ORGANIZATION BEING AUTHORIZED TO RELEASE INFORMATION/RECORD(S)

NAME OF INDIVIDUAL/ORGANIZATION/AGENCY

ADDRESS

CITY	STATE	ZIP CODE

INDIVIDUAL WHO IS SUBJECT OF INFORMATION/RECORD(S)

NAME

ADDRESS

CITY	STATE	ZIP CODE

INFORMATION/RECORD(S) MAY BE RELEASED TO

NAME OF INDIVIDUAL/ORGANIZATION/AGENCY		TELEPHONE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE

PURPOSE OR NEED FOR RELEASE OF INFORMATION

As evidence of my desire to obtain a position with _____, I hereby authorize any official representative of the Wisconsin _____, bearing this release, to obtain information and records pertaining to me and my personal background whether such information and records are public, private, or confidential in nature from any or all of the above sources. I understand that the above information is necessary for determining my eligibility and suitability to obtain a position with the _____. I hereby release any individual or institution, including its officers, employees, or related personnel, both individually and collectively, from any and all liability for damages of whatever kind, which may at any time result to me, because of compliance with this authorization and request to release information or any attempt to comply with it. A copy of this release form will be valid as an original thereof.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

I understand that I may revoke this authorization, in writing, at any time except where information has already been released as a result of this authorization. Unless revoked, this authorization will remain in effect until 6 months from the date I sign this authorization.

As evidenced by my signature below, I hereby authorize disclosure of information/records to the individual agency/organization as specified above.

SIGNATURE OF INDIVIDUAL WHO IS SUBJECT OF RECORD   DATE SIGNED