AUTHORIZATION TO RELEASE INFORMATION
FOR THE PURPOSE OF APPLYING FOR LICENSURE AS A
PROFESSIONAL INVESTIGATOR OR INVESTIGATIVE ASSISTANT
PURSUANT TO 32 M.R.S.A. § 8101-8121

Please Print Legibly or Type

Name of Applicant _____ DOB _____

Alias and/or Prior Name(s): _____

Pursuant to 32 M.R.S.A § 8105, I authorize the Riverview Psychiatric Center and the Dorothea Dix Psychiatric Center to disclose any record of whether I have been involuntarily committed to the Riverview Psychiatric Center or the Dorothea Dix Psychiatric Center to the designee of the Commissioner of the Department of Public Safety.

Department of Public Safety
Maine State Police
Weapons and Professional Licensing
164 State House Station
Augusta, ME 04333-0164

Fax#: (207) 287-3424
Telephone #: (207) 624-7210

I understand that the information requested is protected by law and cannot be released without my written permission, unless otherwise specifically permitted by law. I understand that I have the right to review information and material prior to its release. I understand I have the right to revoke this authorization in writing at any time by contacting the licensing authority identified above. I understand that my refusal to sign this release will cause my application for licensure as a contract security company to be rejected. I understand that if the licensing authority receives an affirmative response to its inquiry, I may be asked to authorize the release of additional information to determine my eligibility for licensure as a Private Investigator or Investigative Assistant.

NOTE: This application is a public record pursuant to 1 M.R.S. § 402(3), and, with the exception of portions identified as confidential by statute (e.g., social security numbers; mental health adjudications), may be disseminated publicly.

This authorization is effective for ninety (90) days following my dated signature.

_____ _____
Applicant Signature Date

_____ _____
Witness Signature Date

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APPLICANT: RETURN THIS FORM TO THE MAINE STATE POLICE, SPECIAL INVESTIGATIONS UNIT, WITH YOUR LICENSE APPLICATION. RETAIN A COPY FOR YOUR RECORDS.

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MAINE STATE POLICE: Send completed form (or a copy) by regular mail with a stamped, self-addressed envelope; OR by fax; OR by e-mail (scan this waiver if using e-mail) to:

Riverview Psychiatric Center, PO Box 724, Augusta ME 04333-0724, Attention Medical Records (fax: 207-287-7127)
and
Dorothea Dix Psychiatric Center, PO Box 926, Bangor ME 04401, Attention Medical Records (fax 207-941-4029)

08/15; 08/20 All previous versions of this form are obsolete.