Department of the Secretary of State
Bureau of Motor Vehicles

Shenna Bellows
Secretary of State

Cathie Curtis
Deputy Secretary of State

Christopher J Ireland
Director of Driver License Services

Authorization to Release Information

Whose information will be disclosed? Please print clearly.

Name: Driver's License Number:

Date of birth: Telephone:

Address: E-mail:

What do you want disclosed? Please check all that apply, or list specifically:

___Driver Medical Evaluation and other related medical history

___Vision examination, vision test results or other related medical and vision history

___Driving record, crash history and driver license status

__Other(please specify):

What is the purpose of this disclosure? _____

___Release my information to: OR ___Obtain my information from:

Name of individual or organization:

Address: Town/City:

State/Province: Zip code:

Telephone: Fax:

E-mail (OPTIONAL): I understand that e-mail and the internet have risks that the office sharing my information cannot control. It is possible that my emailed information could be read by a third party. I accept those risks and still ask to send my information by e-mail. ____INITIAL HERE
Print e-mail address where you want information sent:

AUTHORIZATION FOR RELEASE OF MEDICAL and DRIVING RECORD INFORMATION

I hereby authorize the release of my information by _____ to_____. I understand that this information may be shared with any qualified healthcare professional submitting information pertaining to the disclosed medical history for the purpose of determining my eligibility for a driver's license. This form will remain in effect From: _____To: _____unless cancelled in writing by me at an earlier date.

Signature: _____ **Date:** _____