TOWN OF WESTERLY • POLICE DEPARTMENT
60 Airport Rd, Westerly, Rhode Island 02891
401-596-2022 FAX 401-348-8080

APPLICANT INQUIRY

Instructions:
The following background packet must be completed in full. Please answer each question. Use additional sheets where necessary to complete every section. Please be sure to attach: 1. Copy of your current Driver's License 2. Military Service – Copy of Form DD-214 **3.** Copies of High School Diploma, College Degrees, and Special Certifications and/or Licenses

Applicant History:				
How did you learn about this position?				
Have you ever applied for employment with us?	Yes		No	
Is so, when?				

Personal Identification:							
Name:							
	Last		First			Middle	
Aliases: • Nickname(s) • Maiden Name • Other names you may have or are/have been known by.							
Social Security #: (XXX | XX | XXXX)							
Date of Birth: (MM | DD | YYYY)							
Height:		Weight:		Eye Color:		Hair Color:	
Scars, Tattoos, or Other Distinguishing Marks:							

Contact / Citizenship Information			
Telephone (Day):		Telephone (Cell):	
E-mail:			
Are you a United States citizen?	Yes:		No:
If naturalized, date of naturalization:			
Court:			

Previous Law Enforcement Agency Applications					
Have you previously applied to any Law Enforcement Agency?					
Yes:		No:			
Agency:		State:		Date:	
Agency:		State:		Date:	
Agency:		State:		Date:	
Agency:		State:		Date:	
Agency:		State:		Date:	
Agency:		State:		Date:	
Agency:		State:		Date:	
Agency:		State:		Date:	

Previous Law Enforcement Agency Experience					
Have you ever been employed FULL TIME as a Law Enforcement Officer?					
Yes:		No:			
Agency:		State:		Dates: (From – To)	
Agency:		State:		Dates: (From – To)	
Agency:		State:		Dates: (From – To)	
Agency:		State:		Dates: (From – To)	
Agency:		State:		Dates: (From – To)	
Agency:		State:		Dates: (From – To)	
Agency:		State:		Dates: (From – To)	
Agency:		State:		Dates: (From – To)	

Residence		
List all addresses where you have lived during the past ten (10) years, beginning with your present address. List dates by month and year (MM/YYYY). Attach an extra page if necessary.		
#	Address	Date(s):
1.		
2.		
3.		
4.		
5.		
6.		

Employment History			
Begin with your current or most recent employment. List all employment held for the past ten (10) years including part-time, temporary, or seasonal employment. Include all periods of unemployment. Attach extra pages if necessary.			
1.	Employer:		
	Address:		
Telephone #:		Position Held:	
Supervisor:		Title:	
Supervisor Contact #(s):			
Date From:		Date To:	
Reason for Leaving:			
May we contact this employer, if NO, please explain why not:			
2.	Employer:		
	Address:		
Telephone #:		Position Held:	
Supervisor:		Title:	
Supervisor Contact #(s):			
Date From:		Date To:	
Reason for Leaving:			
May we contact this employer, if NO, please explain why not:			

Employment History - Continued			
3.	Employer:		
	Address:		
Telephone #:		Position Held:	
Supervisor:		Title:	
Supervisor Contact #(s):			
Date From:		Date To:	
Reason for Leaving:			
May we contact this employer, if NO, please explain why not:			
4.	Employer:		
	Address:		
Telephone #:		Position Held:	
Supervisor:		Title:	
Supervisor Contact #(s):			
Date From:		Date To:	
Reason for Leaving:			
May we contact this employer, if NO, please explain why not:			
5.	Employer:		
	Address:		
Telephone #:		Position Held:	
Supervisor:		Title:	
Supervisor Contact #(s):			
Date From:		Date To:	
Reason for Leaving:			
May we contact this employer, if NO, please explain why not:			

Employment History - Continued			
6.	Employer:		
	Address:		
Telephone #:		Position Held:	
Supervisor:		Title:	
Supervisor Contact #(s):			
Date From:		Date To:	
Reason for Leaving:			
May we contact this employer, if NO, please explain why not:			

Disciplinary - Performance History				
Have you ever faced disciplinary action at a job?	Yes		No	
Have you ever been dismissed from a position?	Yes		No	
If yes, to either of the above questions, please list the name of the employer and reason for disciplinary action and/or dismissal.				

Have you ever received an unfavorable performance evaluation at a job?				
Yes		No		If yes, please explain below.

Have you ever been the subject of an internal affairs investigation?				
Yes		No		If yes, please explain below.

Educational History							
1.	High School:						
	Address:						
From:				To:			
2.	College / University:						
	Address:						
Major:				From:		To:	
Graduated:	Yes:		No:		Degree:		
3.	College / University:						
	Address:						
Major:				From:		To:	
Graduated:	Yes:		No:		Degree:		
4.	College / University:						
	Address:						
Major:				From:		To:	
Graduated:	Yes:		No:		Degree:		

Were you ever dismissed / expelled from school, or was any disciplinary action ever taken against you during your academic career?					
Yes:		No:		If Yes:	
School:				Date:	
School:				Date:	
School:				Date:	
Describe the Action Taken:					
List Awards, Honors, Citations, Positions held in School, Athletic Endeavors and other Special Recognitions you have received while attending School.					

Language / Skills / Affiliations				
List any foreign language in which you are fluent. Indicate each area your degree of fluency. Fluency is defined as the ability to express oneself easily and articulately on a variety of topics such as news, history, literature, etc.				
Language:	Reading	Speaking	Understanding	Writing
List any other special skills or qualifications you possess:				
List any and all organizations you are affiliated with:				

Military Record					
Have you served in the U.S. Armed Services?					
Yes:		No:			
Branch:				Dates: (From – To)	
Unit:		Service Number:			
Highest Rank:		Type of Discharge:			

Describe any disciplinary measures taken against you while in the U.S. Armed Services. Include court-martial, captain's masts, company punishment, etc.			
Charge:			
Date:		Agency:	
Age at the time:		Disposition:	
Charge:			
Date:		Agency:	
Age at the time:		Disposition:	
Charge:			
Date:		Agency:	
Age at the time:		Disposition:	
If you received a discharge other than honorable, please provide complete details:			

Personal References			
List three persons that currently know you well and have known you for some time, including how you know this person (i.e., childhood friend, college friend, friend from prior position, neighbor, etc.). These individuals need to be able to describe your long-term personal characteristics and behaviors. Do not list relatives or former employers.			
(1) Name:		How Known:	
Years Known:		Occupation:	
Home Address:			
Business Address:			
Telephone (Day):		Telephone (Evening):	
E-mail:			

(2) Name:		How Known:	
Years Known:		Occupation:	
Home Address:			
Business Address:			
Telephone (Day):		Telephone (Evening):	
E-mail:			
(3) Name:		How Known:	
Years Known:		Occupation:	
Home Address:			
Business Address:			
Telephone (Day):		Telephone (Evening):	
E-mail:			

Immediate Family					
Are you?					
Single:		Married:		Separated:	
Divorced:		Widowed:			
If married:					
Spouse's Name (maiden name / aliases):					
Telephone (Day):					
Telephone (Evening):					
E-mail:					
Date of Birth		Place of Birth:			
Date Married:		City/State:			
If Divorced (Currently or previously):					
Spouse's Name (maiden name / aliases):					
Present Address:					
Telephone (Day):					
Telephone (Evening):					
E-mail:					
Date of Birth		Place of Birth:			
Date Married:		City/State:			
State Which:	Separation:		Divorce:		Annul:
Date of Order:		Court & State:			

Children			
List all children related to you or your spouse (natural, step-children, adopted, and foster):			
(1) Name:		Relation:	
Address:			
Date of Birth		Supported By:	
(2) Name:		Relation:	
Address:			
Date of Birth		Supported By:	
(3) Name:		Relation:	
Address:			
Date of Birth		Supported By:	
(4) Name:		Relation:	
Address:			
Date of Birth		Supported By:	
(5) Name:		Relation:	
Address:			
Date of Birth		Supported By:	

Family			
List all parents, step parents, siblings, step siblings			
(1) Name:		Relation:	
Address:			
Telephone:		E-mail:	
(2) Name:		Relation:	
Address:			
Telephone:		E-mail:	
(3) Name:		Relation:	
Address:			
Telephone:		E-mail:	
(4) Name:		Relation:	
Address:			
Telephone:		E-mail:	

Family - Continued			
List all parents, step parents, siblings, step siblings			
(5) Name:		Relation:	
Address:			
Telephone:		E-mail:	
(6) Name:		Relation:	
Address:			
Telephone:		E-mail:	
(7) Name:		Relation:	
Address:			
Telephone:		E-mail:	
(8) Name:		Relation:	
Address:			
Telephone:		E-mail:	

Financial					
What is your present salary or wage? Please specific hourly/annual.					
Do you have income from any source other than your principal occupation? If yes, please explain below, if no write N/A. Be sure to explain how much, and how often.					
Do you own any real estate?		Yes:		No:	
Value:		Location:			
Value:		Location:			
Value:		Location:			
Value:		Location:			
Do you have a checking account?		Yes:		No:	
Bank Name:					
Address:					
Avg. Balance:					
Do you have a savings account?		Yes:		No:	
Bank Name:					
Address:					
Avg. Balance:					

Financial - Continued
Do you have any other banking/investment accounts? Please describe below.
Have you ever failed to file a federal, state, or local tax return as required by law? If yes, please explain below, if no write N/A.
Have there been or is there currently any tax liens placed on you or a member of your household? If yes, please explain below, if no write N/A.

Financial Obligations			
Give names and addresses of the individuals, educational institutions, or others to whom you are indebted, and the extent of your debt. Include rent, mortgages, vehicle payments, charge accounts, credit cards, loans, child support payments, and any other debts and payments.			
(1) Name:			
Address:			
Type of Account:			
Monthly Payment:		Balance Due:	
(2) Name:			
Address:			
Type of Account:			
Monthly Payment:		Balance Due:	

Financial Obligations - Continued			
Give names and addresses of the individuals, educational institutions, or others to whom you are indebted, and the extent of your debt. Include rent, mortgages, vehicle payments, charge accounts, credit cards, loans, child support payments, and any other debts and payments.			
(3) Name:			
Address:			
Type of Account:			
Monthly Payment:		Balance Due:	
(4) Name:			
Address:			
Type of Account:			
Monthly Payment:		Balance Due:	
(5) Name:			
Address:			
Type of Account:			
Monthly Payment:		Balance Due:	
(6) Name:			
Address:			
Type of Account:			
Monthly Payment:		Balance Due:	
(7) Name:			
Address:			
Type of Account:			
Monthly Payment:		Balance Due:	
(8) Name:			
Address:			
Type of Account:			
Monthly Payment:		Balance Due:	
(9) Name:			
Address:			
Type of Account:			
Monthly Payment:		Balance Due:	

Driving Record					
Driver's Lic. #:		State		Exp. Date:	
Has your driver's lic. Ever been suspended or revoked in any state? If yes, please give date, location and reason. If no write N/A.					
Mo/Yr:		Violation:		Department & State:	
Disposition:					
Mo/Yr:		Violation:		Department & State:	
Disposition:					
Mo/Yr:		Violation:		Department & State:	
Disposition:					
Mo/Yr:		Violation:		Department & State:	
Disposition:					
Mo/Yr:		Violation:		Department & State:	
Disposition:					
Mo/Yr:		Violation:		Department & State:	
Disposition:					
Mo/Yr:		Violation:		Department & State:	
Disposition:					
Mo/Yr:		Violation:		Department & State:	
Disposition:					
Mo/Yr:		Violation:		Department & State:	
Disposition:					
Mo/Yr:		Violation:		Department & State:	
Disposition:					

Driving Record - Continued							
List all accidents in which you have been involved in the last ten (10) years.							
(1)Date:		Department:					
Location:							
Was anyone injured?	Yes:		No:				
Were you found at fault?	Yes:		No:				
Brief description of accident and outcome:							
(2)Date:		Department:					
Location:							
Was anyone injured?	Yes:		No:				
Were you found at fault?	Yes:		No:				
Brief description of accident and outcome:							
(3)Date:		Department:					
Location:							
Was anyone injured?	Yes:		No:				
Were you found at fault?	Yes:		No:				
Brief description of accident and outcome:							

Court Record				
Before answering the following questions, please read carefully: Many individuals who have been arrested or have had criminal charges brought against them incorrectly think that the records have been sealed, expunged, destroyed or no longer in existence. If you were convicted of a crime and have had the conviction expunged, you must disclose the fact of a conviction pursuant to the Rhode Island General Laws 12-1.3-4 regardless of the fact that the matter was expunged or sealed. Any arrest that did not result in a conviction must be disclosed unless the matter has been expunged. Please note that arrests and convictions are not an automatic bar to employment. Any impact will depend on the circumstances.				
Have you ever been arrested?	Yes:		No:	
If you answered yes, please indicate the date, circumstances of arrest(s), and whether a conviction resulted:				
Have you ever pled guilty, nolo contendere or been convicted of any misdemeanor or felony offense (regardless of whether fined or penalty imposed) or are there any criminal charges pending against you?				
Yes:		No:		
If yes, please give the following details:				
(1)Date:		Place/ Department		
Charges:		Final Disposition:		
(2)Date:		Place/ Department		
Charges:		Final Disposition:		
(3)Date:		Place/ Department		
Charges:		Final Disposition:		
(4)Date:		Place/ Department		
Charges:		Final Disposition:		

Court Record - Continued					
Have you ever pled guilty, nolo contendere or been convicted of any misdemeanor or felony offense (regardless of whether fined or penalty imposed) or are there any criminal charges pending against you?					
Yes:		No:			
If yes, please give the following details:					
(5)Date:		Place/ Department			
Charges:		Final Disposition:			
(6)Date:		Place/ Department			
Charges:		Final Disposition:			
(7)Date:		Place/ Department			
Charges:		Final Disposition:			
(8)Date:		Place/ Department			
Charges:		Final Disposition:			
Have you ever been involved in a civil dispute/litigation with any individual or organization?					
Yes:		No:			
If yes, please give the following details:					
(1)Date:		Place/ Department			
Charges:		Final Disposition:			
(2)Date:		Place/ Department			
Charges:		Final Disposition:			
(3)Date:		Place/ Department			
Charges:		Final Disposition:			
(4)Date:		Place/ Department			
Charges:		Final Disposition:			
Have you ever failed to pay court-ordered child support?					
Yes:		No:			
If yes, please describe below:					

Court Record - Continued			
Have you ever been detained, questioned or held on suspicion, fingerprinted, or taken into custody for any reason other than a traffic offense, as an adult or juvenile?			
Yes:		No:	
If yes, please describe below:			
Have you ever been involved in any matters in Family Court such as adjudication of wayward or delinquent, abuse or neglect cases, custody or domestic disputes?			
Yes:		No:	
If yes, please describe below:			

Illegal Drugs and Drug Activity			
The following questions pertain to the illegal use of drugs or drug activity. You are required to answer the questions fully and truthfully, and your failure to do so could be ground for an adverse employment decision or action against you, but neither your truthful responses nor information derived from your responses will be used as evidence against you in any subsequent criminal proceeding.			
Have you ever been involved in the illegal purchase, manufacture, trafficking, production, transfer, shipping, receiving, or sale of any narcotic, depressant, stimulant, hallucinogen, or cannabis for your own intended profit or that of another?			
Yes:		No:	
If yes, please describe below:			

Have you ever used anabolic steroids, other than as prescribed by a physician?				
Yes:		No:		
If yes, please describe below:				

Have you used illegal drugs within the last twelve (12) months?				
Yes:		No:		
If yes, please describe below:				

Are you a medical marijuana cardholder or caregiver?				
Yes:		No:		
If yes, please describe below:				

Are you currently taking any prescribed medications?				
Yes:		No:		
If yes, please describe below:				

Medical				
Do you have any medical condition that may interfere with physical activity?				
Yes:		No:		
If yes, please describe below:				

AUTHENTICATION

I hereby certify that there are no willful misrepresentations, omissions, or falsifications in the foregoing statements and answers to questions. I am fully aware that any such misrepresentations, omissions, or falsifications will be grounds for immediate rejection of this application or subsequent termination of employment.

_____/_____/_____ _____

Date Applicant

State of_____

County of_____

On this_____day of_____, 20_____, before me _____, the undersigned officer, personally appeared_____ and acknowledged that the above information is true and correct to the best of his/her knowledge and belief.

In witness whereof I hereunto set my hand and official seal.

_____

Notary Public/Justice of the Peace

My commission expires:_____/_____/_____

TOWN OF WESTERLY • POLICE DEPARTMENT

60 Airport Rd, Westerly, Rhode Island 02891
401-596-2022 FAX 401-348-8080

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 dully authorized agents of the Westerly 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 Westerly 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 are 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 Westerly 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 here, 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 may original signature.

I hereby release to the Westerly Police Department and the Rhode Island Municipal Police Academy and its agents and anyone who gives written or oral information about me to the Westerly 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:		Social Security Number:	
Witness - Print Name:		Witness – Signature:	

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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 Westerly 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 are 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 Westerly 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 here, 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 may original signature.

I hereby release to the Westerly Police Department and the Rhode Island Municipal Police Academy and its agents and anyone who gives written or oral information about me to the Westerly 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:		Social Security Number:	
Witness - Print Name:		Witness – Signature:	

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) 722-5808 — Fax: (401) 722-3151

Colonel Steven G. O'Donnell
Commissioner, Department of Public Safety
Superintendent, Rhode Island State Police

Lieutenant Scott N. Raynes
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 *ANYTOWN* 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 *ANYTOWN* 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 *ANYTOWN* 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 *ANYTOWN* Police Department and its agents and anyone who gives written or oral information about me to the *ANYTOWN* 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: _____

ARBOUR-FULLER
HOSPITAL
A Division Of Arbour Health System
200 May Street
South Attleboro, MA 02703-5515
(508) 761-8500/FAX (508) 761-4240

AUTHORIZATION TO OBTAIN/RELEASE OF INFORMATION FORM

Patient: _____Date of Birth_____

Patient's Address:_____

I hereby authorize Arbour-Fuller Hospital to: ☐ Obtain From **AND/OR** ☐ Release To

Facility: _____

Address: _____

ATTN: _____ **Fax # (if applicable):**_____

The following information contained in the medical record of the above named patient pertaining to services provided on or about_____. Please check the appropriate information to be released:

☐ Admission Note
☐ Discharge Summary
☐ Physical Examination
☐ Medical Consult
☐ Psychological Testing
☐ Laboratory Data
☐ Treatment Plans
☐ Other (please be specific) _____
☐ Rehab Assessments
☐ Aftercare Plan

The information is needed for the following purpose(s) and may not be redisclosed:
☐ To provide ongoing treatment/aftercare.
☐ Other: _____

I understand that records which refer to treatment of diagnosis of drug or substance abuse are protected under the Federal Regulations (42CFR, Part 2), Confidentiality of Alcohol and Drug Abuse Treatment.

I have read carefully and understand the above statements and do herein expressly and voluntarily consent to disclosure of the above information and/or psychiatric records including alcohol and drug abuse records, if applicable, to those persons/agencies named above.

I further release the Hospital and its employees from any liability arising from the release of this information to such persons/agencies, provided said release of information is done substantially in accordance with applicable law.

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 thereunder.
Once the requested PHI is disclosed, the Privacy Regulations may no longer protect it if the PHI's recipient redisclosures it.

I understand this consent is subject to revocation at any time unless action based on it has already begun. This authorization will automatically expire 90 days from the date it is signed.

My records ☐ may ☐ may not be faxed. _____(please initial).

_____ _____ Date: _____
Signature of Patient/Legal Guardian or Parent if Patient is Under 18 — Relationship to Patient

Witness: _____ Adolescent Signature : _____

AUTHORIZATION to RELEASE H.I.V. INFORMATION

I hereby specifically authorize the release of HIV antibody or antigen testing or records containing HIV, HIV virus or any AIDS related conditions which may be contained in the above referenced request.
SIGNATURE: _____ DATE: _____

BUTLER HOSPITAL
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ _____ Date of Birth: _____
(Please Print)

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): _____

Name (First and Last): _____

Street Address: _____

City/State/Zip Code: _____

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 #: _____
☐ Photocopies
☐ FAX Fax#: _____

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): _____
For Dates of Service: _____

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

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

_____

☐ 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**

McLean HOSPITAL
HARVARD MEDICAL SCHOOL AFFILIATE

Health Information Management
115 Mill Street, Mail Stop139, Belmont, MA 02478-9106
Telephone 617.855.2447

AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION

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

Specific information to be released:

- ☐ Verbal Information/Telephone Update
- ☐ Continuing Care Plan (Inpatient Only)
- ☐ Discharge/Treatment Summary
- ☐ Other *(specify)*_____

Purpose:

- ☐ Treatment
- ☐ Financial
- ☐ Personal
- ☐ Other_____

FROM McLean Hospital
to another person or facility

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

To: ☐Referring/Aftercare Clinician ☐PCP ☐Other

*Name/Facility:*_____

Address: _____

_____

_____

To: ☐Referring/Aftercare Clinician ☐PCP ☐Other

*Name/Facility:*_____

Address: _____

_____

_____

TO McLean Hospital
from another person or facility

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

*Name/Facility:*_____

Address: _____

_____

_____

Information should be sent to:

McLean Hospital
115 Mill Street
Belmont, MA 02478-9106

Attention:

_____
Name of McLean staff member who should receive the information

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the Director of Medical Records. 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 90 days from the date below or as otherwise specified:_____.

Mental Health Information. I authorize disclosure of such information.

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, I authorize disclosure of such information.

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, I authorize disclosure of such information.

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)*

Signature of Witness

_____ _____ _____ _____
Printed Name of Patient or Authorized Person Date Printed Name of Witness Date

McLean HOSPITAL
HARVARD MEDICAL SCHOOL AFFILIATE

Health Information Management
115 Mill Street, Mail Stop139, Belmont, MA 02478-9106
Telephone 617.855.2447

AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION

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

Specific information to be released:

- ☐ Verbal Information/Telephone Update
- ☐ Continuing Care Plan (Inpatient Only)
- ☐ Discharge/Treatment Summary
- ☐ Other *(specify)*_____

Purpose:

- ☐ Treatment
- ☐ Financial
- ☐ Personal
- ☐ Other_____

FROM McLean Hospital
to another person or facility

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

To: ☐Referring/Aftercare Clinician ☐PCP ☐Other

*Name/Facility:*_____

Address: _____

_____

_____

To: ☐Referring/Aftercare Clinician ☐PCP ☐Other

*Name/Facility:*_____

Address: _____

_____

_____

TO McLean Hospital
from another person or facility

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

*Name/Facility:*_____

Address: _____

_____

_____

Information should be sent to:

McLean Hospital
115 Mill Street
Belmont, MA 02478-9106

Attention:

_____
Name of McLean staff member who should receive the information

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the Director of Medical Records. 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 90 days from the date below or as otherwise specified:_____.

Mental Health Information. I authorize disclosure of such information.

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, I authorize disclosure of such information.

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, I authorize disclosure of such information.

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)*

Signature of Witness

_____ _____ _____ _____
Printed Name of Patient or Authorized Person Date Printed Name of Witness Date

U.S. Department of Justice

Certification of Identity

Privacy Act Statement. In accordance with 28 CFR Section 16.41(d) personal data sufficient to identify the individuals submitting requests by mail under the Privacy Act of 1974, 5 U.S.C. Section 552a, is required. The purpose of this solicitation is to ensure that the records of individuals who are the subject of U.S. Department of Justice systems of records are not wrongfully disclosed by the Department. Failure to furnish this information will result in no action being taken on the request. False information on this form may subject the requester to criminal penalties under 18 U.S.C. Section 1001 and/or 5 U.S.C. Section 552a(i)(3).

Public reporting burden for this collection of information is estimated to average 0.50 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Suggestions for reducing this burden may be submitted to Director, Facilities and Administrative Services Staff, Justice Management Division, U.S. Department of Justice, Washington, DC 20530 and the Office of Information and Regulatory Affairs, Office of Management and Budget, Public Use Reports Project (1103-0016), Washington, DC 20503.

Full Name of Requester [1] _____

Citizenship Status [2] _____ Social Security Number [3] _____

Current Address _____

Date of Birth _____ Place of Birth _____

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct, and that I am the person named above, and I understand that any falsification of this statement is punishable under the provisions of 18 U.S.C. Section 1001 by a fine of not more than $10,000 or by imprisonment of not more than five years or both, and that requesting or obtaining any record(s) under false pretenses is punishable under the provisions of 5 U.S.C. 552a(i)(3) by a fine of not more than $5,000.

Signature [4] _____ **Date** _____

OPTIONAL: Authorization to Release Information to Another Person

This form is also to be completed by a requester who is authorizing information relating to himself or herself to be released to another person.

Further, pursuant to 5 U.S.C. Section 552a(b), I authorize the U.S. Department of Justice to release any and all information relating to me to:

_____

Print or Type Name

[1] Name of individual who is the subject of the record sought.

[2] Individual submitting a request under the Privacy Act of 1974 must be either "a citizen of the United States or an alien lawfully admitted for permanent residence," pursuant to 5 U.S.C. Section 552a(a)(2). Requests will be processed as Freedom of Information Act requests pursuant to 5 U.S.C. Section 552, rather than Privacy Act requests, for individuals who are not United States citizens or aliens lawfully admitted for permanent residence.

[3] Providing your social security number is voluntary. You are asked to provide your social security number only to facilitate the identification of records relating to you. Without your social security number, the Department may be unable to locate any or all records pertaining to you.

[4] Signature of individual who is the subject of the record sought.

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: 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 the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. 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 systems of records notices identified as 24VA10P2 "Patient Medical Record - VA" and in accordance with the Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. 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 Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it 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 instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

PATIENT NAME (Last, First, Middle Initial)

SOCIAL SECURITY NUMBER

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

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

DRUG ABUSE ALCOHOLISM OR ALCOHOL ABUSE TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

COPY OF HOSPITAL SUMMARY COPY OF OUTPATIENT TREATMENT NOTE(S) OTHER (Specify)

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

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 the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s):

I understand that the VA health care practitioner'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.

DATE (mm/dd/yyyy)

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA) (Sign in ink)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED

RELEASED BY

Form **8821**

(Rev. March 2015)

Department of the Treasury
Internal Revenue Service

Tax Information Authorization

▶ **Information about Form 8821 and its instructions is at *www.irs.gov/form8821*.**
▶ **Do not sign this form unless all applicable lines have been completed.**
▶ **Do not use Form 8821 to request copies of your tax returns or to authorize someone to represent you.**

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 7.

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

2 Appointee. If you wish to name more than one appointee, attach a list to this form. **Check here if a list of additional appointees is attached** ▶ ☐

Name and address	CAF No.
	PTIN
	Telephone No.
	Fax No.
	Check if new: Address ☐ Telephone No. ☐ Fax No. ☐

3 Tax Information. Appointee 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.

(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

4 Specific use not recorded on 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 lines 5 and 6 . . . . . ▶ ☐

5 Disclosure of tax information (you **must** check a box on line 5a or 5b unless the box on line 4 is checked):

a If you want copies of tax information, notices, and other written communications sent to the appointee on an ongoing basis, check this box . . . . . ▶ ☐

Note. Appointees will no longer receive forms, publications, and other related materials with the notices.

b If you do not want any copies of notices or communications sent to your appointee, check this box . . . . . ▶ ☐

6 Retention/revocation of prior tax information authorizations. If the line 4 box is checked, skip this line. If the line 4 box is not checked, the IRS will automatically revoke all prior Tax Information Authorizations on file unless you check the line 6 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 6 instructions.

7 Signature of taxpayer. If signed by a corporate officer, partner, guardian, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute this form with respect to the tax matters and tax periods shown on line 3 above.

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

▶ **DO NOT SIGN THIS FORM IF IT IS BLANK OR INCOMPLETE.**

Signature | Date

Print Name | Title (if applicable)

Form **4506-T**

(Rev. September 2015)
Department of the Treasury
Internal Revenue Service

Request for Transcript of Tax Return

▶ **Do not sign this form unless all applicable lines have been completed.**
▶ **Request may be rejected if the form is incomplete or illegible.**
▶ **For more information about Form 4506-T, visit *www.irs.gov/form4506t*.**

OMB No. 1545-1872

Tip. Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." under "Tools" or call 1-800-908-9946. If you need a copy of your return, use **Form 4506, Request for Copy of Tax Return.** There is a fee to get a copy of your return.

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
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)

5 If the transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

Caution: If the tax transcript is being mailed to a third party, ensure that you have filled in lines 6 through 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your tax 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 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ▶ _____

a **Return Transcript,** which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120-A, Form 1120-H, Form 1120-L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days . . . . . ☐

b **Account Transcript,** which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days . ☐

c **Record of Account,** which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days . . . . . ☐

7 **Verification of Nonfiling,** which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days . . ☐

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2011, filed in 2012, will likely not be available from the IRS until 2013. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 10 business days . ☐

Caution: If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

9 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately. | / / | / / | / / | / /

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

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note:** For transcripts being sent to a third party, this form must be received 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.

Phone number of taxpayer on line 1a or 2a

Sign Here

▶ **Signature** (see instructions) — Date

▶ **Title** (if line 1a above is a corporation, partnership, estate, or trust)

▶ **Spouse's signature** — Date

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about Form 4506-T and its instructions, go to *www.irs.gov/form4506t.* Information about any recent developments affecting Form 4506-T (such as legislation enacted after we released it) will be posted on that page.

General Instructions

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

Purpose of form. Use Form 4506-T to request tax return information. You can also designate (on line 5) a third party to receive the information. Taxpayers using a tax year beginning in one calendar year and ending in the following year (fiscal tax year) must file Form 4506-T to request a return transcript.

Note: If you are unsure of which type of transcript you need, request the Record of Account, as it provides the most detailed information.

Tip. Use Form 4506, Request for Copy of Tax Return, to request copies of tax returns.

Automated transcript request. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." under "Tools" or call 1-800-908-9946.

Where to file. Mail or fax Form 4506-T to the address below for the state you lived in, or the state your business was in, when that return was filed. There are two address charts: one for individual transcripts (Form 1040 series and Form W-2) and one for all other transcripts.

If you are requesting more than one transcript or other product and the chart below shows two different addresses, send your request to the address based on the address of your most recent return.

Chart for individual transcripts (Form 1040 series and Form W-2 and Form 1099)

If you filed an individual return and lived in:	Mail or fax to:
Alabama, Kentucky, Louisiana, Mississippi, Tennessee, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team Stop 6716 AUSC Austin, TX 73301 512-460-2272
Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Washington, Wisconsin, Wyoming	Internal Revenue Service RAIVS Team Stop 37106 Fresno, CA 93888 559-456-7227
Connecticut, Delaware, District of Columbia, Florida, Georgia, Maine, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Vermont, Virginia, West Virginia	Internal Revenue Service RAIVS Team Stop 6705 P-6 Kansas City, MO 64999 816-292-6102

Chart for all other transcripts

If you lived in or your business was in:	Mail or fax to:
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409 801-620-6922
Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin	Internal Revenue Service RAIVS Team P.O. Box 145500 Stop 2800 F Cincinnati, OH 45250 859-669-3592

Line 1b. Enter your employer identification number (EIN) if your request relates to a business return. Otherwise, enter the first social security number (SSN) or your individual taxpayer identification number (ITIN) shown on the return. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Line 3. Enter your current address. If you use a P.O. box, include it on this line.

Line 4. Enter the address shown on the last return filed if different from the address entered on line 3.

Note: If the addresses on lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address. For a business address, file Form 8822-B, Change of Address or Responsible Party — Business.

Line 6. Enter only one tax form number per request.

Signature and date. Form 4506-T must be signed and dated by the taxpayer listed on line 1a or 2a. If you completed line 5 requesting the information be sent to a third party, the IRS must receive Form 4506-T within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines are completed before signing.

CAUTION *You must check the box in the signature area to acknowledge you have the authority to sign and request the information. The form will not be processed and returned to you if the box is unchecked.*

Individuals. Transcripts of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506-T exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Corporations. Generally, Form 4506-T can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer. A bona fide shareholder of record owning 1 percent or more of the outstanding stock of the corporation may submit a Form 4506-T but must provide documentation to support the requester's right to receive the information.

Partnerships. Generally, Form 4506-T can be signed by any person who was a member of the partnership during any part of the tax period requested on line 9.

All others. See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

Note: If you are Heir at law, Next of kin, or Beneficiary you must be able to establish a material interest in the estate or trust.

Documentation. For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the letters testamentary authorizing an individual to act for an estate.

Signature by a representative. A representative can sign Form 4506-T for a taxpayer only if the taxpayer has specifically delegated this authority to the representative on Form 2848, line 5. The representative must attach Form 2848 showing the delegation to Form 4506-T.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested tax information under the Internal Revenue Code. We need this information to properly identify the tax information and respond to your request. You are not required to request any transcript; if you do request a transcript, sections 6103 and 6109 and their regulations require you to provide this information, including your SSN or EIN. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506-T will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form,** 10 min.; **Preparing the form,** 12 min.; and **Copying, assembling, and sending the form to the IRS,** 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506-T simpler, we would be happy to hear from you. You can write to:

Internal Revenue Service
Tax Forms and Publications Division
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224

Do not send the form to this address. Instead, see *Where to file* on this page.