AUTHORIZATION TO RELEASE RECORDS

I hereby consent to the release of any and all medical, mental health, juvenile, and police records and reports that the Wausau Police Department has in its possession relating to me from the period time of _____ to _____

Release to: _____
(name of organization receiving records)

This consent expires on: _____

Printed Name: _____

Address: _____

Date of Birth: _____

Signed: _____Date_____
Signature of person authorizing release