STATE OF ALASKA
DEPARTMENT OF CORRECTIONS

Authorization for Release of Case Record Information:

____
(Name of Institution or Facility)

TO WHOM IT MAY CONCERN:

I, ____________________________________ , herby authorize and request that the below indicated information
(Full Name of Offender)

be released by the officials of the Department of Corrections to:

____,
(Name, Title and Agency Being Released to)

for the purpose of:

____
____
____.

This authorization will expire on, ______________________ or automatically 180 days after the signature date below. *(Enter Date)*

SPECIFIC INFORMATION AUTHORIZED TO BE RELEASED:
____
____
____
____
____

____ ___________
Signature / Printed Name of Person Authorizing Release: Date:

____ ___________
Signature / Printed Name of Staff / Witness: Date:

Distribution:

Original:	Prisoner Case Record.
Cc:	Prisoner, Probationer or Parolee.
	Person or agency to whom information is released.