ALBANY COUNTY SHERIFF'S OFFICE

CRAIG D. APPLE, SR.
SHERIFF

MICHAEL S. MONTELEONE
EXECUTIVE UNDERSHERIFF

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AUTHORIZATION FOR RELEASE OF INFORMATION

To: **Any Physician, Psychologist, Psychiatrist, Dentist, Optometrist, Hospital, Nursing Home, Medical Association;**
The U.S. Armed Forces, Maritime Service, Veteran's Administration, Selective Service Administration;
Any Academic Dean, Registrar, Principal, Guidance Counselor, or authorized person at any: School, College, University, Business School, Trade School, Elementary or High School;
Any Local, State of Federal Law Enforcement Agency;
Any Past or Present Employer;
Any Credit Bureau or Retail Merchants Association;
Any Insurance Company;
Any Internet Provider;
Any Financial Institution:

I, _____ have applied for a Pistol Permit with the Albany County Sheriff's Office. I am aware that my entire background will be thoroughly investigated and I hereby authorize and request the release of any and all information you have that concerns me, including but not limited to academic transcripts, medical records, and disciplinary records to a representative of the Albany County Sheriff's Office. This authorization or reproduction thereof, shall be valid for a period of one year from the date of execution on this document.

Date of Birth: _____ Place of Birth: _____

Social Security No.:_____ - _____ -_____

Armed Forces Membership (if applicable):_____

Service Number (if applicable):_____

Veteran's Administration File No. (if applicable):_____

_____
Signature

_____
Current Address

_____
City, State, Zip

Sworn before me this _____ day of _____ 20 ____

_____ _____
Signature Title