



**Authorization for Release of Information  
HOSPICE OF SPOKANE**

Please print clearly

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Former Name(s): \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Driver's License Number: \_\_\_\_\_ Issuing State: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Current Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

I hereby authorize Hospice of Spokane, its employees, agents, professional investigators, or any representative of the above named company including Pinnacle and/or American Background, to perform investigations into my background, past behavior, character, and reputation. Including, but not limited to, the records of my incorporated business.

Investigative reports may include nationwide criminal history or arrest records including sex offender status, workers' compensation histories, motor vehicle records, employment and unemployment records, education records, military records, or other sources of information.

I authorize custodians of the records of any agency or company as described herein to release such information upon request of any investigator, agent, or representative of the Company named above. I understand that any or all of these investigations or inquiries can be performed prior to and periodically throughout the duration of my employment or tenure as a volunteer.

I understand that the information requested is for the use by the Company named above and may be re-disclosed only as authorized by law. I understand that I have the right to request from the Company a written disclosure of the nature and scope of the investigation conducted that I authorized above if: (1) Any adverse action/decision is made based on the information in the consumer report & (2) If the request is made in writing within 60 days of the adverse action. If an Investigative Consumer Report has been conducted, I will be notified in writing within five days of receipt of my request for said report.

I believe to the best of my knowledge that all information I have provided is accurate, true, and correct and that I fully understand the terms of this release. I indemnify, release and hold harmless the Company, any agents of the Company, or others reporting to or for the Company, any investigators, all former employers, reporting agencies, and all those supplying references and character references, from any and all claims, defamation, demands, and/or liabilities arising out of, or related to, such investigators, disclosures, or admissions.

Copies and facsimile transmissions of this authorization that show my signature are as valid as the original release signed by me.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

2557

Account Number

EMPLOYEE OR PROSPECTIVE EMPLOYEE REQUEST

That I, \_\_\_\_\_, am an employee or prospective employee of the company named below and that I request a copy of my official Driving Record in the State of Washington be released to my employer or prospective employer or their agent.

Authorization of employee or prospective employee for release of abstract of driving record for employment purposes as defined in (C) below.

Signature Date WA License # or print full name and date of birth

EMPLOYER ATTESTATION

- (A) That the company named below is an employer or prospective employer of the above named individual and that I am a representative authorized to bind said company.
(B) That AMERICAN DRIVING RECORDS is acting as agent on behalf of Pinnacle Investigations who is acting as agent on our behalf to obtain the abstract of driver records of the above named individual.
(C) That abstracts of driver record shall be used exclusively to determine whether the above named individual should be employed to operate a school bus, commercial vehicle or for employment purposes related to driving by an individual as a condition of that individual's employment upon the public highways or otherwise at the direction of the employer or organization, and that no information contained therein shall be divulged, sold, assigned, or otherwise transferred to any third person or party.
(D) That the information contained in the abstracts of driver records obtained from the Department shall be used in accordance with the requirements and in no way violate the provisions of RCW 46.52.130, attached in part for easy reference.

By affirming my signature below, I declare under penalty of perjury, under the laws of the State of Washington, that the foregoing is true and correct.

Hospice of Spokane
Company Name

121 S Arthur, Spokane, WA 99202
Address

Carey A. Butler HR Admin.
Authorized Officer's Name Title

Carey A Butler
Signature Date