



Release of Information – Volunteer

I, _____, authorize the Verified Credentials to release any criminal records that have been compiled on me to Age Well Arrowhead. I understand that any criminal records will be an influencing factor in determining my eligibility as an Age Well Arrowhead volunteer. I understand that I have data privacy rights under the Minnesota Government Data Practices Act and the federal Health Insurance Portability and Accountability Act (HIPAA). I understand the information being provided is voluntary and is only used to determine if placement is appropriate.

Full Name

Signature

Date

Notary

Date