



CLEVELAND DIVISION OF POLICE RELEASE FORM

I am the spouse/parent/legal guardian/next of kin of the below-named missing/wanted person and I hereby authorize the release and dissemination of medical records, dental records and photographs to the Cleveland Division of Police to use to locate/identify the named person. Medical and dental records will be kept confidential to the extent of the law. Photographs may be made public and disseminated through the media or through other law enforcement channels.

Missing/Wanted Person

Name: _____ **D.O.B. :** _____

Authorizing Signature: _____

Printed Name of Authorizing person: _____

Address: _____

Phone/Contact: _____

Relationship to Missing Person: _____
(Spouse, Parent, Legal Guardian, or Next of Kin)

Approximate Date of Photo: _____

Date person last seen: _____

Today's Date: _____

RMS# _____

Assigned Detective (name/badge): _____
(if assigned)

Original: to District Detective Unit Missing Person Investigator
Copy: attached to original RMS report (with any other attachments) and forwarded to the Report Intake & Review Unit