******* Fill out the "From" line; leave "To" section blank; Sign and Date *******

COUNTRYSIDE HEALTH CARE OF MILFORD
ONE COUNTRYSIDE DRIVE
MILFORD, MASSACHUSETTS 01757
TEL: (508) 473-0435

AUTHORIZATION TO RELEASE INFORMATION

From: ____

c/o Countryside Health Care of Milford
One Countryside Drive
Milford, MA 01757

To: ____

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I have applied for a position with Countryside Health Care of Milford. As part of my application, I have been requested to provide information concerning my background and qualifications. Therefore, I authorize the investigation of my past and present work, character, education, military experience, and my employment qualifications by Countryside Health Care of Milford.

The release in any manner of any and all information by you to Countryside Health Care of Milford indicated above is authorized whether such information is of record or not. I do hereby release all persons, agencies, firms, companies, etc., from any responsibility for damages resulting from their provisions of such information.

This authorization is valid for 90 days from the date of my signature below. Please keep this copy of my release for your files. Thank you for your cooperation.

____ ______________

Signature Date

~We Care ~

Revised March 2015