



# 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:** \_\_\_\_\_

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**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