Authorization for Release of Information

I authorize and direct you to release any and all records in your possession that contain information related to my identity, as requested by the Bureau of Consumer Protection. Copies of records shall be sent to the Wisconsin Bureau of Consumer Protection, PO Box 8911, Madison, Wisconsin 53708-8911.

The Wisconsin Bureau of Consumer Protection and other cooperating law enforcement agencies will use this information to investigate my complaint of Identity Theft.

I understand that, as a victim of identity theft, I am entitled to obtain copies of records that contain information related to the fraudulent use of my identity and to direct that copies of these records be sent to any federal, state, or local law enforcement agency I specify, in accordance with the federal Fair Credit Reporting Act (FCRA, 15 U.S.C. 1681 et seq.).

A copy of this authorization shall be as valid as the original. This authorization shall be valid for a period of one year from the date it is signed.

Signed: _____

Dated: _____

Print Name: _____

Print Address: _____