



The North Dakota Air National Guard does NOT maintain an official copy of the member's record after discharge. All ND ANG records of member discharged prior to 1990 are stored on microfiche and can be difficult to copy. Records after 1990 are of good copy quality.

To obtain a complete copy of an official military record utilize the following web site:  
<http://www.americanwarlibrary.com/htomr.htm#1> or contact the National Archives Records Center  
1 Archives Drive, St. Louis, MO 63138 Phone: 314-801-9195 fax: 314-801-9195  
<http://www.archives.gov/> or Email: [MPR.center@nara.gov](mailto:MPR.center@nara.gov)

## AUTHORIZATION FOR RELEASE OF INFORMATION

Name \_\_\_\_\_ DOB \_\_\_\_\_

Maiden/Other Name \_\_\_\_\_ SSN \_\_\_\_\_ SN \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Branch of Military: \_\_\_\_\_ AD/NG/Res \_\_\_\_\_ Dates of Service: \_\_\_\_\_ Rank: \_\_\_\_\_  
(Circle one)

I hereby authorize \_\_\_\_\_ Joint Forces Headquarters- MPMO-A1  
Name person/facility  
PO Box 5511, Bismarck, ND 58506-5511  
Address of person/facility

To release to \_\_\_\_\_  
Name of person/facility to receive information (if it is the same as above just write same.)  
Address of person/facility to receive information  
Telephone: \_\_\_\_\_ FAX: \_\_\_\_\_

### The following information:

\_\_\_\_\_ DD Form 214 (Active Duty discharge) \_\_\_\_\_ NGB Form 22 (NG discharge)  
\_\_\_\_\_ NGB Form 23 (Retirement History)  
\_\_\_\_\_ Other: (Specify)

### Reason for Request:

### Requestor's Consent:

This authorization is voluntary and remains in effect unless specifically revoked by written notice to the facility or person or expires on \_\_\_\_\_. If an expiration date is not entered, authorization will expire one year from date of signature. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by this rule. A photocopy of this release is as effective as the original. If Power of Attorney is used, a copy of Power of Attorney must accompany request.

Signature of Person or Responsible Party \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_  
*Meets requirements of Health Insurance Portability and Accountability Act of 1996 (PL 104-191)*

Send completed form(s) to: JFHQ, MPMO - Air, PO Box 5511, Bismarck, ND 58506-5511  
POC: MSgt Nelson, 701-451-2656