

**CHEROKEE COUNTY MENTAL HEALTH COURT**

**CRIMINAL HISTORY CONSENT FORM**

I hereby authorize the Cherokee County Mental Health Court and its representatives to receive any criminal history record information pertaining to me, which may be in the files of any criminal justice agency of any state or local criminal justice agency in the State of Georgia. This consent shall remain in effect for seven (7) years from the date this form is executed.

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Full Name

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Sex/Race/Date of Birth

\_\_\_\_\_  
City/State/Zip Code

\_\_\_\_\_  
Driver's License/ID Number/State