# AUTHORIZATION FOR RELEASE OF EMPLOYMENT INFORMATION

**Employee Information:**

_____

(PRINT name) DOB SS#

**Information to be released from:**

Facility Name_____

Address_____

**I request and authorize the above named facility to release all employment information of the employee named above to:**

Medrecs, Inc
PO Box 4186
Seattle, WA 98194-0186 (206) 624-1420

**Information to be Released:**

All employment records to include but not limited to: Application, hours worked, disciplinary actions, benefit programs, profit sharing records, payroll, absence records, vacation time, incident reports and claims, correspondence, medical records, employee reviews and labor & industries records.

**Purpose for which disclosure is being made: (Please check one of the following)**

_____Attorney/Legal _____Insurance _____Personal

**Employee Authorization:**

I understand that my express consent is required to release any information relating to my employment at _____. This includes but is not limited to all information in my employee file and all information contained in my employment records dating since the first day of my employment at _____.

**My Rights:**

I understand that authorizing the use or disclosure of the information above is voluntary. I may revoke this authorization in writing at any time. To view the process for revoking this authorization, please read the Privacy Notice posted at the facility where your information is being released. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that once the information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

_____ _____

Signature of Employee or Employee's Authorized Representative Date Signed

**This Authorization will expire 90 days from the date signed**

**A photocopy or facsimile shall be counted true and valid as original.**