



RELEASE OF INFORMATION AUTHORIZATION

MUST BE WITNESSED OR NOTARIZED

Name:	Social Security Number: <i>For identification purposes only</i>
-------	--

I authorize the State of Oregon Employment Department, to release the following information from my records

(Please **initial** those that apply)

Name, address, telephone number and demographic information
 Services that I have received or will receive
 Work history and other information that I provided for job placement purposes
 Wage record information
 Unemployment insurance information (i.e. ECLM and/or Wage & Benefit report, etc.)
 TAA services information (i.e., training, job search & relocation) and/or TRA unemployment insurance information
 Other (must be specifically identified below)

I am authorizing the release of this information to the following individual or organization:

The purpose for the release:

I understand that information obtained under the release will **only be used** for the above purpose or purposes.

I understand this authorization will be in effect until canceled in writing by me (for placement information) or for the duration of my unemployment insurance claim (for UI information).

I understand that information in my records is confidential and that I approve the release of the information listed above.

I understand that state government files will be accessed to obtain the information.

Releasing this information to this party will provide a service to me or benefit me.

I understand the purpose of this authorization.

I am signing on my own and have not been pressured to do so.

Signature:	Date:
------------	-------

NOTE: Rediscovery of any information received is strictly prohibited

WorkSource Oregon is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Language assistance is available to person with limited English proficiency at no cost.

WorkSource Oregon es un programa/empleador que respeta la igualdad de oportunidades. Ayudas auxiliares y servicios para personas con discapacidades estará disponible sin costo. Asistencia de idiomas para personas con conocimiento limitado del inglés sin costo alguno.

EMPLOYMENT DEPARTMENT	ONE-STOP PARTNER*
<p>If witnessed by Employment Department staff the portion below must be completed.</p> <p>Printed name of witness: _____</p> <p>Signature of witness: _____</p> <p>Field Office: _____</p>	<p>If witnessed by a one-stop partner* the portion below must be completed. Partners should retain this document and submit it to the Employment Department with any/each request for information.</p> <p>Partner organization: _____</p> <p>Printed name of witness: _____</p> <p>Signature of witness: _____</p> <p>Telephone number of witness : _____</p>
NOTARY	
<p>If notarized the following must be completed:</p> <p>State of: _____ County: _____</p> <p>Signature (of notary): _____</p> <p>Commission expires: _____</p>	<p>*Authorized partner staff must have signed the Employment Department's Commitment to Confidentiality</p>