State of Oregon Employment Department

RELEASE OF INFORMATION AUTHORIZATION
MUST BE WITNESSED OR NOTARIZED

Name:	Social Security Number: *For identification purposes only*

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:

RECORDS DEPOSITION SERVICE, INC., PO BOX 5054, SOUTHFIELD, MI, 48086-5054

The purpose for the release:

PRE TRIAL DISCOVERY

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: Redisclosure of any information received is strictly prohibited

EMPLOYMENT DEPARTMENT

If witnessed by Employment Department staff the portion below must be completed.

Printed name of witness: _____

Signature of witness: _____

Field Office: _____

NOTARY

If notarized the following must be completed:

State of: _____ County: _____

Signature (of notary): _____

Commission expires:

ONE-STOP PARTNER*

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.

Partner organization: _____

Printed name of witness: _____

Signature of witness: _____

Telephone number of witness : _____

****Authorized partner staff must have signed the Employment Department's Commitment to Confidentiality***