

## 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)		
<ul> <li>Name, address, telephone number and demographic information</li> <li>Services that I have received or will receive</li> <li>Work history and other information that I provided for job placement purposes</li> <li>Wage record information</li> <li>Unemployment insurance information (i.e. ECLM and/or Wage &amp; Benefit report, etc.)</li> <li>TAA services information (i.e., training, job search &amp; relocation) and/or TRA unemployment insurance information</li> <li>Other (must be specifically identified below)</li> </ul>		
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		
	X I	
I understand that information obtained under the release will onl I understand this authorization will be in effect until canceled in w for the duration of my unemployment insurance claim (for UI informat I understand that information in my records is confidential and I understand that state government files will be accessed to obtain Releasing this information to this party will provide a service to make the purpose of this authorization. I am signing on my own and have not been pressured to do so.	y be used for the above purpose or purposes. riting by me (for placement information) or ation). that I approve the release of the information listed above. in the information.	
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EMPLOYMENT DEPARTMENT	ONE-STOP PARTNER*
If witnessed by Employment Department staff the portion below must be completed.	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.
Printed name of witness:	Employment Bopartinent with any each request for information.
Signature of witness:	Partner organization:
Field Office:	Printed name of witness:
NOTARY	Signature of witness:
If notarized the following must be completed:	Tolonkon wombon of a three or
State of: County:	Telephone number of witness :
Signature (of notary):	*Authorized partner staff must have signed the Employment Department's Commitment to Confidentiality
Commission expires:	,