AUTHORIZATION TO DISCLOSE EMPLOYMENT, PAYROLL, & UNION INFORMATION

Name: **Social Security Number:**
Date of Birth:

1. I authorize the use or disclosure of the above named individual's information as described below:

2. The following individual or organization is authorized to make the disclosure:

3. **That the Records Custodian of the above-named agency is authorized to produce and deliver copies of all personnel, payroll and union records, including but not limited to, all wage records, personnel records, job application forms and documents of any kind or nature.**

4. That copies so produced shall be identified as the complete records of plaintiff herein, and further identification at the time of trial waived, but that objections as to competency, materiality or relevancy are reserved until the time of trial.

5. This information may be disclosed to and used by the following individual or organization:
T-Scan Corporation, 4200 23rd Avenue West, Seattle, Washington 98199,
for the purpose of adjudicating person's law suit or claim.

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire ninety days from date of signature.

7. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I understand I may inspect or copy the information to be used or disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

8. I understand and agree that a copy or facsimile of my signature will be counted as valid as the original.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of attorney or witness