AUTHORIZATION FOR THE RELEASE OF

PERSONNEL / PAYROLL RECORDS

Employees Name	Date of Birth	Social Security #	
Address		Telephone	

I hereby authorize ____
(Company Name)

To release information from the employment/payroll/workers comp. records of:

____
Employee

To: **Discovery Resource, 1511 West 34th Street, Houston, Texas 77018**
Name/address of person/organization to which disclosure is to be made

Fax # 713-228-3311 Phone #: 713-223-3300

For the following purpose:

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I specifically authorize the release of the following:

_____ Employment application

_____ Payroll/salary records

_____ Letters of Commendation/Discipline

_____ Performance evaluations

_____ Vacation use records

_____ Other: *(Specify)* ______________________________

_____ All Records in the departmental personnel file

This authorization is valid until the 180th day after it is signed, unless it provides otherwise, not to exceed 24 months, or unless it is revoked.

I, the undersigned, have read and authorize the release of such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used to disclose pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above named facility and its parent company from all liability and damages resulting from the lawful release of my protected health information.

_______________ ______________________________

Date Signature of Employee