AUTHORIZATION TO RELEASE INFORMATION

Name: _____
DOB: _____
SSN: _____

AUTHORIZATION FOR RELEASE OF INFORMATION AND FOR RE-DISCLOSURE

I, _____, authorize_____and/or any of its affiliates to disclose and deliver to:

_____ whose address is _____
Phone: _____; Fax:_____the following information:

The personnel file of _____including, but not limited, to rate of pay information, benefit information, all performance reviews, all disciplinary action records, all notes for visits to the company nurse, and all attendance information.

This authorization expires on _____. I understand the information disclosed pursuant to this Authorization to Release Information may be re-disclosed as needed.

I understand I have a right to inspect the disclosed information at any time and I hereby invoke that right and require, as a condition precedent to the use of the Authorization, that the attorney _____or any attorney in the law firm of _____, receiving any personnel information through the use of this Authorization provide my attorney of record notice each time this authorization is used and, in addition, promptly provide copies of all information received through use of this authorization in accordance with Rule 1.500(c)(1) of the Iowa Rules of Civil Procedure.

I understand I may refuse to sign this authorization or revoke this authorization at any time. I further understand that if I revoke this authorization, the revocation will take effect on the day it is received by the entity from which disclosure is sought in writing.

I SPECIFICALLY AUTHORIZE AND CONSENT TO THE DISCLOSURE AND RE-DISCLOSURE DESCRIBED ABOVE.

Date: _____

_____