The Golden Scoop
Authorization For Exchange of Information

Employee Name:_____

Date of Birth:_____Telephone #:_____

Street Address_____City:_____State:_____Zip: _____

I hereby authorize The Golden Scoop to exchange information, including health and employment information, with:

Agency &/or Person_____

Agency &/or Person_____

Agency &/or Person_____

This release covers all employment records, medical records, including diagnosis, evaluations, assessments, school records, and other information that my be relevant to the parties. This authorization is valid for information to be exchanged in any format, including but not limited to: written, audio/visual, electronic/digital, verbal. Please list below if there are any records you do not consent to releasing:

_____Release of all information _____I do NOT authorize the release of these records:

_____

I understand the information in my health record may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that this authorization may be revoked by the person named above and/or their guardian at any time except to the extent the action has already taken place. I understand that if I revoke this authorization I must do so in writing and present my written revocation to leadership or Human Resources. **Unless otherwise revoked, this authorization will expire one year from date of signature**.

I have read the above Authorization for Release of Information / Permission to Obtain and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this release.

Date:____/____/____Signature of Employee:_____

(**Please complete the following section if signed by a Parent, Guardian, or Authorized Representative)

Date:____/____/____Signature of Authorized Representative:_____

Printed Name of Parent/Guardian or Authorized Representative:_____

Street Address:_____City:_____State:_____Zip: _____

Phone:_____Relationship to the Employee: _____