

Authorization to Release Records - Individual

FIRST MIDDLE LAST NAME OF INDIVIDU	A. AUTHORIZATION TO DISCLOSE CONFIDENTIAL UNEMPLOYMENT INSURANCE PROGRAM RECORDS: FIRST MIDDLE LAST NAME OF INDIVIDUAL					
FIRST MIDDLE LAST NAME OF INDIVIDUAL						
SOCIAL SECURITY NUMBER (NEED TO PROCESS REQUEST):						
COCIAL GEOGRATI NOMBER (NEED TO TROCEGO REGOLOT).						
B. DISCLOSE RECORDS TO:						
NAME LAST	FIRST		TITLE (IF APPLICABLE)			
ORGANIZATION OR BUSINESS NAME (IF APPLICABLE)						
ADDRESS	CIT	r st	ATE ZIP CODE			
TELEPHONE NUMBER	FAX NUMBER	EMAIL ADDRESS				
STATE PURPOSE OF DISCLOSURE (REQUIRED):						
C. RECORDS AUTHORIZED TO RELEASE:						
I authorize the following confide	ential unemployment insurance	program informati	on and records to be released			
to the third party entity identified						
provide the requested information	on/records. The identified third	I party entity is only	authorized to use the			
requested information/records f	or the stated purpose.					
☐ A copy of my Wages Re	eported by employers in the St	ate of Washington f	☐ A copy of my Wages Reported by employers in the State of Washington from			
	through	- nh				
(start date	through through through through the through through the through th	·				
(start date	through the far back as 1987)	·	end date)			
		·				
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	e – far back as 1987) yment Payment History from: throu	(1)	end date)			
☐ A copy of my <u>Unemploy</u>	e – far back as 1987) yment Payment History from: through (start date)	gh	end date)			
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☐ A copy of my Unemploy ———————————————————————————————————	yment Payment History from: through (start date) dividual's wages reported a d release on-line to receive s	gh nd/or unemploym	end date) (end date) ent payment history then			
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This form should not be emailed as it may contain personal sensitive information.

Any questions contact the ESD Records Disclosure Unit at 1-844-766-8930