



NOTARIZED AUTHORIZATION FOR RELEASE OF RECORDS
AGENCY FOR WORKFORCE INNOVATION
UC Benefit Records, PO Box 5750, Tallahassee, Florida 32314-5750

This authorization is for the release of confidential information contained in the records of the Agency for Workforce Innovation

SECTION I

- I applied for Florida UC benefits within the past year and have completed Section II and provided my signature in Section IV.
- I am requesting information from your records pertaining to the individual identified in SECTION II who has authorized the release of this information to me through signature and attestation of identity required by SECTION IV below.

The information I am requesting is:

- Claim documents Computer printout of benefit payments
- Other (Please specify) _____

SECTION II

This form is hereby freely executed by:

Name: _____ Social Security Number: _____
(First, Middle, Last) (Social Security Number Required for Record Retrieval)
 Address: _____
 City: _____ State: _____ Zip Code: _____ Date of Birth: _____
(mm/dd/yy)
 Telephone: _____

SECTION III

I authorize the Agency for Workforce Innovation to release the records requested in its possession pertaining to *(check one)* me or the individual indicated below. I understand the information may include records that reveal my identity, the amount of UC benefits received, medical records, or other evaluations including any drug test information, and/or the identity of employing units for which I have worked. If requested, the information may include the identity of the employing unit to which I was referred for employment.

If this request involves a court case, please provide the following:

I further authorize the Agency for Workforce Innovation and any of its employees to appear and provide oral testimony regarding my records and other information requested by subpoena, in any deposition, hearing or other proceeding relevant to:

Case Style: _____ Case Number: _____
 Which is now pending in jurisdiction _____
 (Identify court/administrative body). This authorization is valid until the above styled case is concluded.

The information requested is to be provided to a party other than indicated in SECTION II; please forward the information in to:

Name: _____
 Address: _____
 Mailing City: _____ State: _____ Zip Code: _____
 Telephone: _____

SECTION IV

Signature of person

Who is the subject of this request: _____ ***Date:*** _____

State of Florida

County of _____

The foregoing instrument was acknowledged before me this _____ day of _____ 20____ by _____

 SIGNATURE

 (NAME OF NOTARY, TYPED, PRINTED OR STAMPED)

Personally Known _____ **OR Produced Identification** _____

Type of Identification Produced _____