AUTHORIZATION FOR INFORMATION RELEASE

PLEASE PRINT CLEARLY	
Employee Name:	
Social Security Number:	Date Requested:
Information to be Released (be specific):	

Please send the information to: *(check one)*

☐ Mail: Name _____

Address _____

City _____ State _____ Zip _____

☐ Fax number: _____ Attention:_____

☐ Other: _____

THIS REQUEST WILL NOT BE PROCESSED WITHOUT A VALID SIGNATURE.

I authorize ProService to disclose any information in its possession that it deems necessary to satisfy the request described above and release ProService from any and all liability in connection with such disclosure.

Employee Signature: _____ Date: _____

COMPLETE, SIGN AND SUBMIT THIS FORM VIA:

Mail: **ProService Hawaii**
6600 Kalanianaole Hwy., Ste. 200
Honolulu, HI 96825

OR

Toll Free Fax: 888.783.8333

ProService HAWAII