Montefiore | Nyack

AUTHORIZATION FOR RELEASE OF INFORMATION

Please Print Clearly

I, _____ hereby give written consent and authorize Montefiore Nyack Hospital to release the information indicated below.

It is the policy of Montefiore Nyack Hospital to maintain and uphold the confidentiality of employee records, both active and former employees. Please be advised that Montefiore Nyack Hospital only verifies dates of employment and job title for Verification of Employment.

Please indicate information requesting:

☐Employment Verification Letter**

Recipient Name: _____ Phone#: _____ Fax#: _____

Mailing Address: _____

☐Copy of License or certification, please indicate: _____

☐Other, please indicate: _____

_____

**Employment Verification letters will be provided directly to the recipient named above. Letters will not be provided directly to employees.

Employee Signature: _____ Date: _____

Employee ID#: _____ Dept: _____ Contact#: _____

For HR Office Use:

Request processed by: _____ Date: _____