Associate Authorization to Release Employment Information Form

I understand and authorize the release of my entire employment personnel file and associate health records from Ministry Saint Joseph's Hospital/Ascension to Marshfield Clinic Health System. I hereby release Ministry Saint Joseph's Hospital/Ascension and its associates, agents, officers and affiliates from any and all liability, responsibility, claims and damages which may result from the release of information authorized by this Associate Authorization to Release Employment Information Form. It is my understanding these records will be released after the change in my employment to Marshfield Clinic Health System. In addition, I authorize the transfer of my unused PTO/FLTO balance to be effective as of the date of sale of Ministry Saint Joseph's Hospital to Marshfield Clinic Health System.

I have read and understand the Associate Authorization to Release Employment Information Form and have voluntarily and knowingly signed such consent.

_____ _____ _____

(Print Name) First Name Middle Initial Last Name

_____ _____

Position Title Department

_____

EMPL ID/Associate Number

_____ _____

Employee Signature Date