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PAYCHECK RELEASE AUTHORIZATION

In the event you would like to designate someone else to pick up you paycheck; complete this information below.

I _____, authorize _____ to pick up my paychecks. I understand that Life Fountain Home Health Care Inc. is not responsible for the paycheck once it is signed for and leaves the office.

By signing this authorization I understand that only I or the above stated individual(s) will be allowed to pick up my paycheck.

Signature

Date

REMINDER: Please remember photo ID's are required to pick up paychecks. This form requires ORIGINAL signatures (no copies or stamps).