CONSOLIDATED EDISON COMPANY OF NEW YORK, INC.
OCCUPATIONAL HEALTH GRIEVANCE AUTHORIZATION

I, ______________________ [Employee Name], ________ [Employee Number], request that the Consolidated Edison Occupational Health Department ("Occupational Health") release health information regarding my care and treatment as set forth in this authorization. I authorize Consolidated Edison's Human Resources Department ("HR") and UWUA Local 1-2's Business Agent or designee ("Local 1-2") to use, disclose, and discuss my health information as may be required in order to review my grievance. Specifically, I authorize the release of my records regarding my absence from ________ (date) to ________(date). I authorize HR and Local 1-2 to receive and use the identified protected health information from Occupational Health and my private health care providers in an effort to resolve my grievance.

I understand that this authorization may include disclosure of information relating to alcohol and drug abuse, mental health treatment, except psychotherapy notes, and confidential HIV-related information only if I place my initials here _______. In the event the health information described above includes any of these types of information, and I placed my initials where instructed, I specifically authorize release of such information to HR and Local 1-2.

If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, HR and Local 1-2 are prohibited from re-disclosing such information without my authorization, except as necessary to attempt resolution of my grievance, unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

I understand that I have the right to revoke this authorization at any time by notifying HR in writing at 4 Irving Place, 15th Floor, New York, NY 10003 or by fax at (718) 246-7554. I understand that the revocation is only effective after it is received and logged by HR.

I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. I understand that after this information is disclosed, it may be re-disclosed, and the law might not protect it. I understand that I am entitled to receive a copy of this authorization. I understand that this authorization will expire at the earlier of six months or the resolution of my grievance.

Signature of Employee: ___________________________ Date: _________________

Return to: Heather Zakrewski
HR - Labor & Wage
4 Irving Pl, M020
15th Floor
New York, NY 10003
Fax # 718-246-7554