



Utility Workers Union of America, Local 1-2
 5 West 37th Street, New York, NY 10018 – 7th Floor
 Phone: (212) 575-4400 Fax: (212) 575-3852

AUTHORIZATION FOR RELEASE OF MEDICAL & SURGICAL RECORDS

I, _____, authorize _____
Member Name Doctors Name

to release the records described below to the persons or organizations described below for the purposes described below:

The information that may be released is the following:

Person or organization to whom the records to be released:

 Name

 Address City State Zip

The information may be used for the following purposes:

The authorization is valid from the date signed until the following date or event:

_____. However, I may revoke this consent at anytime, except to the extent that action has been taken in reliance on it.

_____ I explicitly consent to the release of **Alcohol and Drug Abuse patient Records.**

Initials

I understand that Alcohol and Drug Abuse Patient Records are protected by federal regulations 42 CFR Part 2.

 Member Name

 Date

Please return completed form to:

**UWUA, Local 1-2
 5 West 37th Street, 7th Floor New York, NY 10018
 or via fax to: (212) 575-3852**