Utility Workers Union of America, AFL-CIO

Local 1-2

8 East 36th Street New York, NY 10016
(212) 575-4400

GRIEVANCE REPORT

Member's Name ____ Employee No. ___________

Home Address ____ Phone No. ______________

E-mail ____ Title ___________________

Dept/ Bureau ____ Company ________________

Location ____ Supervisor _____________________

Nature of Grievance—**PLEASE CHECK THE APPROPRIATE BOX BELOW**

- ☐ Termination
- ☐ Suspension
- ☐ Denied Progression
- ☐ Denied Merit
- ☐ Other (Warnings) Give a brief explanation below.

____

____

Clause of Contract Violated (list articles violated)

____

Remedy ☐ To be made whole, including but not limited to any lost wages, benefits, merit increases and progressions.

☐ Other (Give a brief explanation below)

____

____

Today's Date __________________ Signature of Member ____________________________

CONSOLIDATED EDISON COMPANY OF NEW YORK, INC.
MEDICAL GRIEVANCE AUTHORIZATION

I, ______________________ [Employee Name], ________ [Employee Number], request that the Consolidated Edison Employee Wellness Center ("EWC") 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 EWC 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: Melissa Contreras
Employee Wellness Center
4 Irving Pl,
11th Floor
New York, NY 10003
contrerasm@coned.com

Employee Wellness Center
4 Irving Place, New York, NY 10003 - 11th Floor North

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, ______________________________ ____________________
Employee Name Employee No.

Authorize Con Edison's Occupational Health Department 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 records are to be released:

____
Name Phone #

____
Address City State Zip

If you are requesting records to be released to someone other than yourself, please fill out the remainder of the form.

If your records are being released to you, please leave the rest of this form blank, except the signature.

The information may be used for the following purposes:

____

____

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

____________________ However, I may revoke this consent at any time in the future by providing written notice of revocation to Con Edison's Medical Records Department at the address listed below, with the revocation to take effect on the date notice is received by the Medical Records Department.

______________________ ______________ ____________
Employee Signature Employee No. Date

Please submit completed form to: Email: MedicalRecords@coned.com, Fax: 212-387-2129 or Con Edison, Medical Records Department, 4 Irving Place, New York, NY 10003 - 11th Floor North.