Utility Workers Union of America, Local 1-2
8 East 36th Street, New York, NY 10016
Phone: (212) 575-4400

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