

Communications

Local 9510



Workers of America

Affiliated with AFL-CIO

606 N ECKHOFF STREET
ORANGE, CALIFORNIA 92868-1004
TELEPHONE (714) 978-9510

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, hereby authorize _____, to release and discuss any medically related information in their possession relating to diagnosis, prognosis, treatment and billing with respect to any physical, dental, medical condition and/or any other non-medical information concerning me, to my CWA Representative.

I understand that the information obtained by use of this authorization will be used by the party or parties to whom it is released for the purpose of discussion of company benefits and/or State or Federal laws.

I agree that a photocopy of this authorization shall be as valid as the original.

Date: _____

Employee Signature

Employee ID #