

Fax This Form to:

Labor, Sr. Staff Consultant

Fax: (NY/NE) CWA

212-395-0723 or 212-764-0506

VERIZON LABOR RELATIONS
MEDICAL INFORMATION RELEASE FORM

I, _____ hereby authorize and request that a copy of all of my medical records be released to the Union and Labor Relations Representatives listed below. I understand that this report may contain personal medical and/or psychological information. In addition, I authorize METLIFE to forward any medical information, i.e. records and all recorded telephone conversations provided by my attending physician pertaining to this grievance number.

Union Official

Labor Relations

Anthony Caudullo

Sr. Staff Consultant

President CWA Local 1106

Verizon Labor Relations

Office: (718)479-1106

Office: _____

Fax: (718) 479-1128

Fax: _____

I understand that I can withdraw my consent, in writing, at any time and that the following receipt of such withdrawal of consent, no further information will be released. If I do not withdraw my consent, this permission to release information will automatically expire 90 days from the date of signing.

Date

Employee's Signature

Employee's Social Security Number

Date

Union Official Signature