AUTHORIZATION FOR RELEASE OF
MEDICAL RECORDS TO MEDICAL SPECIALIST

TO: _____

RE: _____ (Patient)

DATE: _____

You are hereby authorized and directed to allow Dr. _____, the Medical Specialist designated by the Joint Foremen's Labor Relations Committee ("JFLRC") under the PCWB&FA, whose office is located at _____, and/or its representatives to examine and copy the complete medical records of the above-patient in your files concerning the following medical condition and/or disability _____.

This includes all billing records, x-rays and reports, history, laboratory findings, hospital admission and discharge reports, treatment records, diagnosis and prognosis records, notes of any medical providers such as doctors, nurses, assistants and/or technicians and all medical reports.

This authorization shall remain valid during the pendancy of my request for workplace accommodations in connection with the above-described medical condition.

A photocopy of this authorization may be accepted in place of the original. By signing this authorization, I acknowledge that I have received a copy thereof.

Dated: _____ _____
Patient Signature

Patient Name (Printed): _____
Street Address: _____
City: _____ State: _____ Zip Code:_____
Telephone Number: _____

TO THE PATIENT: By law, you have the right to receive a copy of this authorization.

For Office Use Only:

Dated Received by JFLRC:
Copy Provided to Employee:
Copy sent to Medical Specialist:

Initials: