Grievance #:_______________________

Date sent to Grievant:__________________

MEDICAL INFORMATION RELEASE FORM

This authorization to receive or release information is being requested of you to comply with the terms of the California Confidentiality of Medical Information Act.

AUTHORIZATION

I ,_____________________________, hereby authorize and request release _______________

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to the Communications Workers of America for the purpose of processing the grievance through its contractual stages.

This authorization will automatically expire after all activities in connection with the above stated purpose have been fulfilled.

I understand I have the right to receive a copy of this authorization.

Dated:___________________ SIGNATURE:_________________________________

Copy Requested: YES/NO

Copy Received: YES/NO