COMMUNICATIONS WORKERS OF AMERICA

SPECIFIC WRITTEN CONSENT AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PART A

I, _____________________________, hereby authorize _____________________________ to release, provide copies to, otherwise allow "access" to my "Designed Representative," _________________________________, to my Medical Records, any and all medical reports or evaluations, clinical or surgical records, graphically recorded patient data, test results or laboratory interpretations, notes, observations, charts, progress reports, records or summaries prepared by any health care professional, X-rays, to any examination, evaluation or treatment of any nature whatsoever given to me or for me by any and all doctors, hospitals, clinics or any other medical person or facility which may be in your possession on the date of this Authorization, or which may thereafter come into your possession, whether in existence on the date of this Authorization or not, which my "Designated Representative" requests to examine, review or copy as part of its representation of me concerning ___________________________. You are also authorized to discuss the matter fully with my "Designed Representative," and to copy for my "Designated Representative" any written material within the scope of this Authorization.

In executing this Authorization, I specifically release you from all legal liability or responsibility relating to the disclosure of this information orally or in writing or by providing copies of written material within the scope of this Authorization, and further waive on behalf of myself and any persons who may have an interest in the matter, any and all claims of privilege or confidential communications between myself and any doctor, physician or any other health care professional who may have examined me or conferred with those who have examined or treated me.

Unless you receive written revocation of this Authorization from me, it shall remain in effect for one (1) year from its date, at which it will expire; provided, however, that the revocation shall not be effective tot he extent that action has been previously taken in reliance upon this release and consent. Copies of this Consent and Authorization shall be as effective as the original.

Separate express consent is required to release any information concerning testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use (see Part B).

Date and signed this ______________day of _____________________________, 2____.

STATE OF ______________________________
COUNTY OF ____________________________
CITY OF ________________________________

COMMUNICATIONS WORKERS OF AMERICA

SPECIFIC WRITTEN CONSENT AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PART B
(MUST BE ATTACHED TO PART A)

If I have tested, diagnosed or treated for:

_________ (a) HIV (AIDS virus),

_________ (b) Sexually transmitted diseases,

_________ (c) Psychiatric or mental health disorders,

_________ (d) Drug and/or alcohol use,

you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

Dated and signed this ______________day of ______________________________, 19_______.

STATE OF __________________________________

COUNTY OF________________________________

CITY OF____________________________________