SAMPLE AUTHORIZATION FORM

Date:	
To:	(Name of Person Possessing Information)
Title:	(Title)
Company:	(Company Name)
Address:	(Address)
	(City, State, Zip)
Phone:	(Phone)
Release to:	(Name of Person to Whom Information is Released)
Title:	(Title)
Union:	(Union and Local)
Address:	(Address)
	(City, State, Zip)
Phone:	(Phone)
Release from:	(Name of Person Releasing Information)
SSN:	(Social Security Number)
DOB:	(Date of Birth)

AUTHORIZATION FORM

I, _____, hereby authorize and designate _____, as my representative for the purpose of gaining access to occupational safety and health records which relate to me.

Date:_____ Signature:_____