

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: _____