BRAND SAFWAY

Release of Records

Last Name	First Name		Social Security Number
Street Address	City	State	Zip Code

I _____ *(insert full name),* hereby authorize any physician that treats me for any job-related injury during my employment with BrandSafway or any of its subsidiaries to have access to and release full medical records covering that injury.

I authorize copies and/or faxes and/or electronic communications to be sent to BrandSafway or any of its subsidiaries and agree that the copies and/or faxes and/or electronic communications will be deemed as correct/valid as original documents.

I hereby authorize BrandSafway or any of its subsidiaries or affiliates to BrandSafway provide results of drug tests conducted on specimens I provide to state officials and others involved in the process of claims for unemployment compensation. In addition, I authorize BrandSafway to rely upon the results of the drug tests conducted on specimens I provide in making decisions concerning my employment with BrandSafway.

By signing below, I certify that I have read the above information, received a copy of the documents, and I agree to the conditions of hiring.

_____ _____

Signature Date