

MEDICAL RELEASE

I, _____ HEREBY AUTHORIZE

DR. _____

St. Address

City

State

Zip

TO RELEASE TO THE TRUSTEES OF THE TRI-STATE CARPENTERS AND JOINERS DISTRICT COUNCIL OF CHATTANOOGA, TENNESSEE AND VICINITY PENSION FUND ANY INFORMATION OF A MEDICAL NATURE PERTAINING TO MY CLAIM FOR DISABILITY PENSION BENEFITS FROM THE FUND.

I UNDERSTAND IF THERE IS A CHARGE FOR SAID SERVICES, I WILL BE RESPONSIBLE FOR PAYMENT OF SUCH CHARGES.

DATE

SIGNATURE