



**AUTHORIZATION FOR RELEASE OF INFORMATION  
FOR PAID FAMILY LEAVE BONDING (ROI)**

First Name:	Last Name:	Claim Nbr (Mandatory):
Street Address:		
City, State and Zip:	Telephone:	
Employer Name:	Last Day Worked:	First Day Away From Work:
<b>COMPLETE THE FOLLOWING STEPS:</b> <b>STEP 1:</b> Complete all information above. NOTE: Your Sedgwick CMS claim number is mandatory for identification purposes. <b>STEP 2:</b> Sign and return this form by <b>fax to (818) 591-7664</b> OR by mail to Sedgwick CMS, P.O. Box 9830, Calabasas, CA 91372-0830. Sedgwick CMS only needs one copy of this form, so please choose one method of delivery only.		

**CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION**

I certify that all of the information above is to the best of my knowledge and belief true, correct and complete. I hereby authorize all claim processors appointed by my employer, including but not limited to those who administer my employer's Group Health, Paid Family Leave, Short-Term Disability, Long-Term Disability, Workers' Compensation and Employee Assistance Program (EAP) to use, disclose, release and furnish all facts evidencing, referring, relating to or concerning my request for a leave of absence, including all personal information about me.

I hereby further authorize the above persons or organizations, any insurer, claims administrator, and my employer(s) to disclose or furnish to Sedgwick CMS, my employer, or any of their authorized representatives, all facts concerning my wages or earnings and benefit payments, that are within their knowledge.

I understand that this information will be used to determine my eligibility for benefits or compensation to which I may be entitled under any benefit plan or practice of my employer. I further authorize disclosure of my personal information to others by Sedgwick CMS, my employer, or any of their authorized representatives, in order to determine my eligibility for, process, evaluate and administer all claims for benefits or compensation for which I may be entitled. I acknowledge that photocopies of this authorization shall be as valid as the original. I understand this authorization is valid for the duration of my claim for benefits or twenty-four months, whichever is earlier. I understand I may keep a copy of this authorization.

**IMPORTANT INFORMATION ABOUT YOUR RIGHTS**

I may revoke this authorization at any time before its expiration date by notifying Sedgwick CMS in writing, but the revocation will not have any affect on any actions any party took before it received the revocation. I understand that my personal information may be released to others in accordance with the terms of this release and I have a right to receive a copy of this information.

*Redisclosure of my protected health information by Sedgwick CMS or any other party is no longer protected by the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")*

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Employee's Social Security Number

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Name of Personal Representative who has Authority to Sign on Behalf of the Employee

\_\_\_\_\_  
Signature of Personal Representative who has Authority to Sign on Behalf of the Employee