



Sedgwick CMS

CARE RECIPIENT'S AUTHORIZATION FOR RELEASE OF INFORMATION FOR PAID FAMILY LEAVE (ROI)

INSTRUCTIONS FOR CLAIMANT: Fill in the information below on yourself and your care recipient. When completed, provide this form to your care recipient (or their personal representative) for their signature. Return this form by fax to (818) 591-7664 OR by mail to Sedgwick CMS, P.O. Box 9830, Calabasas, CA 91372-0830.

Claimant's First Name:	Claimant's Last Name:	Claim Nbr (Mandatory):
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CARE RECIPIENT'S INFORMATION:	
First Name:	Last Name:
Street Address:	
City, State and Zip:	
Telephone: ()	Date of Birth:

THE INFORMATION BELOW IS FOR REVIEW AND SIGNATURE BY THE CARE RECIPIENT (OR THEIR PERSONAL REPRESENTATIVE):

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, including but not limited to those who administer my Health Insurance, Short-Term Disability, Long-Term Disability and Workers' Compensation to use, disclose, release and furnish all facts concerning my health condition.

I hereby further authorize the above persons or organizations and any physician, surgeon, authorized medical officer of a U.S. government facility, chiropractor, podiatrist, optometrist, dentist, designated psychologist, religious practitioner, hospital, clinic, other medical or health facility, pharmacy, insurer, and my claims administrator, to disclose or furnish to my care provider, Sedgwick CMS, or any of its authorized representatives, all facts concerning my health condition (including physical, mental health, alcohol, substance abuse and HIV related information), that are within their knowledge and to allow inspection of and provide copies of any medical records (including diagnosis, symptoms, prognosis, prescriptions or medications, psychiatric, drug or alcohol abuse treatment) and, if applicable, a statement by my medical provider setting forth the facts of my serious health condition that warrants the participation of my care provider.

I understand that this information will be used to determine my care provider's eligibility for benefits or compensation. I also understand my medical provider will not condition my treatment based on this authorization. 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 care provider's 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 information concerning my personal health condition 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")

Care Recipient's Signature

Date Signed

Name of Personal Representative who has Authority to Sign on Behalf of the Care Recipient

Signature of Personal Representative who has Authority to Sign on Behalf of the Care Recipient