



AUTHORIZATION FOR RELEASE OF INFORMATION FOR PAID FAMILY LEAVE (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:
COMPLETE THE FOLLOWING STEPS: STEP 1: Complete all information above. NOTE: Your Sedgwick CMS claim number is mandatory for identification purposes. STEP 2: Sign and return this form by fax to (818) 591-7664 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 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 concerning my personal information.

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")

Claim Nbr (Mandatory): _____

***Important:** The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking you and your health care provider not to provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Employee's Signature

Date of Birth

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

NOTE: ALL PAGES OF THIS RELEASE OF INFORMATION MUST BE RETURNED WITH YOUR SIGNATURE.