



AUTHORIZATION FOR RELEASE OF INFORMATION FOR SELF-INSURED DISABILITY BENEFITS (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:
<p>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.</p>		

CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

I certify all of the information above is to the best of my knowledge true, correct and complete. I hereby authorize the use or disclosure of my personal health information upon request by Sedgwick CMS from all claim processors appointed by my employer, including but not limited to those who administer my employer's Group Health, Short-Term Disability, Long-Term Disability, Workers' Compensation and Employee Assistance Program (EAP).

I hereby further authorize the above persons or organizations, any physician, medical practitioner, hospital, clinic, other medical or medically related facility, pharmacy, 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 medical condition and disability (including physical, mental health, alcohol, substance abuse and HIV related information), wages or earnings, that are within their knowledge and to allow inspection of and provide copies of any medical records (including diagnosis, prognosis, prescriptions or medication, psychiatric, drug or alcohol abuse treatment).

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, which requires evaluation for physical or mental condition, including, but not limited to, a leave from work for medical reasons. I further authorize disclosure of my personal health 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 also understand my healthcare provider will not condition my treatment based on this authorization. I acknowledge my right to make a copy of this authorization. I understand this authorization is valid for the duration of my claim for disability benefits or twenty-four months, whichever is earlier. A photocopy of this authorization is as valid as the original.

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 the party took before it received the revocation. I understand that my personal health 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. I understand that if a recipient of the health information is not governed by federal and state confidentiality laws, the health information disclosed as a result of this authorization may be re-disclosed by the recipient and 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