Authorization for Release and Use of Medical Information

I authorize the use and disclosure of any and all of my individually identifiable medical or health information (as described below) to Sedgwick Claims Management Services, Inc. ("Sedgwick") and/or any of their agents, representatives or independent contractors, for purposes of administering my disability claim(s) (which may include assisting me in returning to work, or applying for Social Security Disability Insurance benefits), workers' compensation claim(s) or request for employment leave or for reasonable accommodation.

I specifically authorize physicians, nurses and hospitals including Kaiser Permanente to communicate my individually identifiable medical or health information by any means, including written or telephonic communications or by direct interview, whether or not I am present during, or notified of, such communications, and I hereby authorize Sedgwick to initiate and conduct such communications whether or not I am present or have received notice thereof.

What Information is covered by this Authorization? This authorization applies to all medical and non-medical information that is needed by____________________, its parent, subsidiaries and affiliates, its administrators and its insurers related to any of the following: request for reasonable accommodation; workers' compensation claim; claim for disability benefits; claim for FMLA; or claim for leave. My information to be disclosed may include, but is not limited to, medical or health history, (but not psychotherapy notes) chart notes, prescriptions, diagnostic test results, x-ray reports, records received from other health care providers, information regarding pre-existing health or medical conditions or illnesses, as well as my occupation and employment activities, employee/employment records, applications for insurance coverage, prior claim files and claim history.

If directly related to my claimed condition or illness, this information may include the following, Please check yes or no and initial:

HIV test results, HIV or AIDS	Yes	No ☐	Initial	___________
Psychiatric information.	Yes	No ☐	Initial	___________
Information related to drug or alcohol	Yes	No ☐	Initial	___________

1. Who may disclose and receive Information under this Authorization?

   A. Any person or facility that attends, treats or examines me, any pharmacy benefits manager, any financial institution, accountant, tax preparer, insurance company, consumer reporting agency, insurance support organization, employer, government agencies including the Social Security Administration, any group policyholder, contract holder or benefit plan administrator to disclose or any other person or organization that possesses any of the information described above, is authorized to make this information available to Sedgwick, and or any of their agents,

representatives or independent contractors.

B. When relevant to my claim(s) or request(s), Sedgwick is authorized to re-disclose any and all of my individually identifiable medical or health information (whether obtained pursuant to this authorization or otherwise from any person or entity) to any of the following: (a) Any person or facility that attends, treats or examines me; (b) Any person or facility that impacts determination of my claim or that coordinates my benefits;
(c) My employer and its affiliates and their representatives, agents, independent contractors, insurers, benefit administrators and service providers that may receive any such information from my employer to the extent permitted by state or federal law; (d) The Social Security Administration or a social security or vocational rehabilitation vendor.

2. How long this Authorization is Valid? If I do not revoke this authorization in the manner set forth below, this authorization will be valid for 24 months from the date I sign this form or during the duration of my claim(s), whichever period is shorter.

3. Revocation of this Authorization. Unless otherwise provided by federal or state law, I understand that I may revoke this authorization at any time by notifying in writing, Sedgwick at, PO Box 14648, Lexington, KY 40512-4648; Fax: (855) 800-5116 of my revocation and that my revocation shall be effective as to Sedgwick upon Sedgwick's receipt of my notice of revocation. I also understand that my revocation of this Authorization will not have any effect on any actions taken by Sedgwick before receiving my revocation.

4. Processing of Claims. I understand that my failure to sign this Authorization may impair or impede the processing of my claim or request for reasonable accommodation.

5. Refusal to Sign. I further understand my health care providers will not condition my treatment, payment, enrollment or eligibility on my refusal to sign this Authorization.

I understand that I have the right to request and receive a copy of this authorization. I understand that the information about me that I authorize to be used or disclosed may be re-disclosed as permitted or required by law by the recipient thereof and may no longer be protected by federal or state privacy laws or regulations. A photocopy of this authorization shall be valid and is to be accepted with the same effect as the original.

"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 that you not 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."

______________________________ ______________________________

Printed Name of Patient or Patient's Representative | Representative's Relationship to Patient, if applicable

______________________________ ______________________________ ______________________________

Claim Number | Last 4 Digits of Patient's SSN | Patient's Date of Birth

______________________________ ______________________________

Signature of Patient or Patient's Representative | Date Signed