RE: Employee: Claim No:
Employer: UCLA/UCLA MC

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEDICAL INFORMATION:

So that Sedgwick may process your claim for workers' compensation benefits, please complete and return this form as soon as possible. A return envelope is enclosed.

For purposes of this document the term "Information" shall include all medical records, hospital and outpatient records, reports, charts, notes, histories, laboratory records and reports, diagnostic test reports, doctors' and nurses' notes, correspondence, radiological films, charges, and all other materials concerning, describing or relating to any and all care, treatment, and/or evaluation received by the undersigned.

AUTHORIZATION

The undersigned hereby authorizes Sedgwick, and/or its authorized representative or designee, to review, inspect, copy, and/or photograph any and all Information you have concerning, describing or relating to:

1. The evaluation and/or diagnosis of any mental or physical condition for which workers' compensation is now being claimed;
2. Any treatment or therapeutic regimen prescribed or recommended for any mental or physical condition for which workers' compensation is now being claimed;
3. Any and all functional limitations relating to my ability to perform my current job duties;
4. Any modification of my current job duties that is necessitated by the mental or physical condition for which workers' compensation is now being claimed. (Such Information shall include, without limitation, the Doctor's First Report of Injury & Illness (DFR), Verification of Treatment (VOT), work slips, etc.)
5. The medical rationale for any limitation identified in Item 3 above, including specifically and without limitation, a finding that I am unable to work as a result of the mental or physical condition for which workers' compensation is being claimed;
6. Any other physical and/or mental condition, irrespective of whether such condition first occurred before or after the onset of the condition for which workers' compensation is now being claimed, that has affected, may affect or is in any way related to, the onset, nature, scope, duration, prognosis or resolution of the physical or mental condition for which workers' compensation is now being claimed.

The released information is required for the following reason:

To provide for adequate preparation, investigation, evaluation, review, and discovery of a claim for workers' compensation benefits. Specifically, to determine the nature of causation and the nature and extent of any possible pre-existing, concurrent or aggravating medical conditions that might have medical, legal or factual implications in the injury or injuries as listed on my Employee Claim Form (the DWC Form 1).

A refusal to authorize access to some or all of the requested Information may result in a delay in processing my claim for workers' compensation benefits and/or a denial of my claim.

Release records and information regarding:

Name of Patient (List Other Names Used)	***Medical Record Number***	*Date of Birth (please verify)*
Address	*Telephone Number*	*Soc Sec # (please verify)*

Release medical information to: Sedgwick and

Name of Receiving Party

P.O. Box 14533 Lexington KY 40512-4533

Address City State Zip

DURATION: I understand that this authorization shall become effective immediately upon execution and shall remain in effect until one year from the date of my signature.

REVOCATION: I understand that this Authorization may be revoked in writing by the undersigned at any time. Written revocation will be effective upon receipt, but will not be effective to the extent that Sedgwick or any disclosing party (medical or healthcare provider) has previously acted in reliance upon this Authorization.

REDISCLOSURE: I expressly authorize Sedgwick to disclose my Information to any employee, representative, agent, or third person as may be necessary for the proper evaluation and processing of my claim. I understand that the third persons to whom my Information may be given include, without limitation, attorneys, nurse case managers, rehabilitation specialists, physicians and other experts and consultants engaged by Sedgwick to assist it in the evaluation and management of my claim. Any such disclosure to third persons will be made in confidence and in accordance with the provisions of any applicable law. I also understand that Sedgwick may disclose my Information in any manner that is required by law (e.g., subpoena, court order, etc.)

SPECIFY RECORDS: Check the box and initial which type of information is to be disclosed.

☒ **MEDICAL INFORMATION** _____ *Initial*

☐ **PSYCHIATRIC INFORMATION**

_____

Signature *Date*

☐ **DRUG/ALCOHOL INFORMATION**

_____

Signature *Date*

☐ **RESULTS OF AN HIV BLOOD TEST**

_____

Signature *Date*

☐ **OTHER HEALTH INFORMATION** (specify) _____

A photocopy of this authorization is as valid as the original.

I have read this authorization and fully understand its entire contents. I understand that by signing this form I am authorizing ALL PROVIDERS to release my Information as provided for above. I have asked questions about anything that was not clear to me and am satisfied with the answers I have received. I understand that I have a right to receive a copy of this authorization upon my request.

_____ _____

Signature of Patient or Patient's Representative *Date*

_____ _____

Indicate Relationship (if Signed by Other Than Patient) *Date*