RELEASE OF INFORMATION TO "FAMILY"

HIPAA-COMPLIANT AUTHORIZATION FOR REEDGROUP'S RELEASE OF MEDICAL AND DISABILITY CLAIMS INFORMATION (PURSUANT TO 45 CFR 164.508)

Claimant's Full Name: _____
Date of Birth: _____
Social Security Number (last 4 digits only): xxx-xx-_____
Employer's Name: _____

I authorize and request ReedGroup, Ltd. ("**ReedGroup**") to communicate information contained within medical documents, disability and leave administrative claims files and/or protected healthcare information ("**Documents**") that may be in ReedGroup's custody and control and to speak with and to share that information with _____("**Recipient**") who is my _____[**choose from spouse, daughter, grandson, domestic partner, nephew, friend, etc**]. The information ReedGroup is hereby authorized to share with Recipient may include, but is not limited to, Documents about my medical condition, treatment, supplies, expenses, coverage or benefits, or my employment, vocation, education, training, income, disability or ability to work, whether maintained prior to or within (1) year after the Effective Date of this Authorization.

This Authorization may include disclosure of Documents relating to treatment for **ALCOHOL, DRUG ABUSE, GENETIC DOCUMENTS, HIV RELATED DOCUMENTS, and MENTAL HEALTH CARE** except psychotherapy notes, but only if I place my initials on the appropriate lines below. In the event my Documents include any of these 5 types of Documents and I initial the line below, I specifically authorize release of the Information contained in such Documents to Recipient.

_____

Include in my Documents (*Indicate by Initialing*):

_____ Alcohol/Drug Abuse Treatment
_____ Mental Health Document
_____ Sexually Transmitted Diseases (STDs)
_____ AIDS/ HIV-Related Documents
_____ Family & Genetic Documents

ReedGroup will tell the Recipient receiving the information that the information is confidential. I understand the HIPAA law requires that I be advised that Documents and information released to any designated Recipient may be re-disclosed by Recipient to other parties where state and federal privacy laws may not protect it.

The Purpose of allowing ReedGroup to share my information and Documents with the Recipient is to allow them to _____ ("**Purpose**").
Any signed facsimile or copy of this Authorization shall authorize ReedGroup to share information and my Documents for the above-stated Purpose.

This Authorization shall be in force and effect for one (1) year from date of execution, at which time this Authorization expires. If I change my mind before then, I can tell ReedGroup in writing that I do not want Recipient to obtain any more information or Documents, although that will not change any actions ReedGroup took before receiving my letter.

I understand that signing this Authorization is voluntary and that I have had the opportunity to consult with an attorney about signing this Authorization and all my questions about this Authorization have been answered. If I do not sign this form, it will not affect my treatment, payment, enrollment in a health plan, or eligibility for benefits.

_____

Signature of Claimant Effective Date

THIS AUTHORIZATION FOR RELEASE OF RECORDS AND INFORMATION IS IN 14-PT FONT IN COMPLIANCE WITH CALIFORNIA LAW AT CAL.CIV.CODE §56.11.