SVFPD Claim#: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

EMPLOYER: **Scotts Valley Fire Protection District (SVFPD)**
EMPLOYEE:
DATE OF INJURY:

This authorization to release medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1980, California Civil Code § 56 et scq.

I hereby authorize physicians, healthcare practitioners, hospitals or other medical or medically related facilities to provide to Sedgwick or an agent of Sedgwick, any and all records pertaining to medical history, services rendered or treatment given to me for purposes of review, investigation or evaluation of the above workers' compensation claim.

This authorization shall become effective immediately and shall remain in effect as long as necessary for Sedgwick, to complete its investigation of the above workers' compensation claim.

I understand that the same restrictions for release of medical information apply to Sedgwick as to the above listed medical providers and that no further authorization is made than is specifically indicated in this form. I further understand that I have a right to receive a copy of this authorization upon my request.

Employee requested and received copy: ☐ Yes ☐ No

Signature: _____

Witness: _____

Date: _____

Please have employee sign and return to:

Sedgwick
PO Box 14852
Lexington, KY 40512