Employment Development Department
State of California

Claim for Disability Insurance (DI) Benefits

250104121

Health Insurance Portability and Accountability Act (HIPAA) Authorization

Claimant Social Security Number

Claimant Name (First) (MI) (Last)

I authorize

(Person/Organization providing the information) to furnish and disclose all my health information and to allow inspection of and provide copies of any medical, vocational rehabilitation, and billing records concerning my disability for which this claim is filed that are within their knowledge to the following employees of the California Employment Development Department (EDD): Disability Insurance Branch examiners, their direct supervisors/managers and any other EDD employee who may have a need to access this information in order to process my claim and/or determine eligibility for State Disability Insurance benefits.

I understand that EDD is not a health plan or health care provider, so the information released to EDD may no longer be protected by federal privacy regulations. (45 CFR Section 164.508(c)(2)(iii)). EDD may disclose information as authorized by the California Unemployment Insurance Code.

I agree that photocopies of this authorization shall be as valid as the original.

I understand I have the right to revoke this authorization by sending written notification stopping this authorization to EDD, DI Branch MIC 29, PO Box 826880, Sacramento, CA 94280. The authorization will stop on the date my request is received. I understand that the consequences for my revoking this authorization may result in denial of further State Disability Insurance benefits.

I understand that, unless revoked by me in writing, this authorization is valid for fifteen years from the date received by EDD or the effective date of the claim, whichever is later. I understand that I may not revoke this authorization to avoid prosecution or to prevent EDD's recovery of monies to which it is legally entitled.

I understand that I am signing this authorization voluntarily and that payment or eligibility for my benefits will be affected if I do not sign this authorization. The consequences for my refusal to sign this authorization may result in an incomplete claim form that cannot be processed for payment of State Disability Insurance benefits.

I understand I have the right to receive a copy of this authorization.

Claimant Signature (Do Not Print)	Date Signed M M D D Y Y Y Y

SAMPLE