Employment Development Department
State of California

Claimant SSN: _____
Claimant Name: _____
CED: _____
Care Recipient Name _____

Declaration of Individual Acting as Authorized Representative for Incapacitated or Deceased Care Recipient

(COMPLETE BOTH PAGES 1 AND 2 OF THIS FORM)

I, _____, authorize the Employment Development Department to disclose my personal information, which is contained on this form, to the care recipient, the care recipient's authorized representative, and the physician or practitioner certifying hereon to the care recipient's mental incompetence or physical incapacity.

Signature of Claimant:_____ Date signed: _____

I, _____, residing at _____
NAME OF REPRESENTATIVE STREET ADDRESS

_____, declare that I am the _____ of
CITY, STATE, ZIP CODE RELATIONSHIP

_____, hereinafter "care recipient." I declare that I am authorized by law to
NAME OF CARE RECIPIENT

Authorize release of medical records of the care recipient for purposes of establishing the claimant's eligibility for Paid Family Leave benefits.

☐ **Deceased**. I declare that care recipient died on _____ at _____
MONTH, DAY, YEAR CITY

_____, _____.
COUNTY STATE

☐ **Mentally Incompetent**. I have been informed by _____ that care
PHYSICIAN OR PRACTITIONER

recipient is not mentally competent to authorize release of his/her medical records for purposes of establishing eligibility for Paid Family Leave benefits.

Doctor's Certification: I hereby certify that the above-named care recipient is under my care and that, based on my examination, care recipient is mentally unable to authorize release of his/her medical records. I further certify that I am a _____ duly authorized by the Employment Development Department.
TYPE OF PHYSICIAN OR PRACTITIONER

_____ _____
PRINT OR TYPE NAME AS SHOWN ON LICENSE SIGNATURE OF ATTENDING PHYSICIAN OR PRACTITIONER

_____ _____
ADDRESS STATE LICENSE NUMBER

_____ _____
TELEPHONE NUMBER DATE

Claimant SSN: _____

☐ **Physically Incapacitated**. I have been informed by _____ that care
PHYSICIAN OR PRACTITIONER

recipient is physically incapable of signing an authorization to release his/her medical records.

Doctor's Certification: I hereby certify that the above-named care recipient is under my care and that, based on my examination, care recipient is physically unable to authorize release of his/her medical records. I further certify that I am a _____ duly authorized by the Employment Development Department.
TYPE OF PHYSICIAN OR PRACTITIONER

_____ _____
PRINT OR TYPE NAME AS SHOWN ON LICENSE — SIGNATURE OF ATTENDING PHYSICIAN OR PRACTITIONER

_____ _____
ADDRESS — STATE LICENSE NUMBER

_____ _____
TELEPHONE NUMBER — DATE

Appointment by Care Recipient: I, _____, residing at
CARE RECIPIENT

_____, _____, _____, hereby appoint
CITY — COUNTY — STATE

_____ as my true and lawful agent, herein "representative," to authorize
REPRESENTATIVE

release of my medical records to the care provider and to the Employment Development Department for purposes of establishing my care provider's claim for Paid Family Leave benefits. Due to my inability to sign my name, I hereby authorize and direct my above-named representative to sign my name to this document.

Done in the presence of two witnesses.

_____ _____
SIGNATURE OF CARE RECIPIENT **DO NOT PRINT** — DATE

By _____
SIGNATURE OF REPRESENTATIVE

_____ _____
SIGNATURE OF WITNESS — SIGNATURE OF WITNESS

_____ _____
ADDRESS — ADDRESS

I understand that this Declaration is made for the sole purpose of releasing the care recipient's medical records to establish the care provider's eligibility for Paid Family Leave benefits. I accept the responsibilities and obligations arising from acting on behalf of care recipient in accordance with the California Unemployment Insurance Code and authorized regulations pertaining thereto.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed at _____, _____, _____
CITY — COUNTY — STATE

► _____ _____
SIGNATURE OF REPRESENTATIVE — DATE