PO Box 6248
Broomfield, CO 80021

MEDICAL DISCLOSURE AUTHORIZATION

I hereby provide the following authorization to all physicians and health care professionals, hospitals and other healthcare institutions, insurers, employers, and group policy holders: You are authorized to provide Reed Group, P.O. Box 6248, Broomfield, CO 80021, acting on my employer's behalf, with information concerning my health care, history, examination, treatment (including but not limited to copies of my medical record), advice, and supplies provided to me, and any employment-related information regarding my primary and/or secondary diagnoses as they relate to my medical leave of absence request. This information may include HIV test results, HIV or AIDS information, psychiatric information and information related to drug or alcohol abuse.

This information will be used to evaluate and administer my application for medical leave and may be reviewed by authorized medical and/or human resources professionals affiliated with my employer. In the event that my absence may extend beyond the Long Term Disability (LTD) qualifying period, I further authorize the release of my medical case information to The Standard, DePaul University's LTD carrier.

I understand that any health information disclosed pursuant to this authorization will no longer be protected by the HIPAA Privacy Rule when received by Reed Group.

When relevant to my claim, Reed Group may re-disclose (without further authorization) this information to any of the following, (a) Any person or facility that attends, treats or examines me; (b) Any person or facility that impacts the determination of my claim or that coordinates my benefits, including without limitation the employer to the extent permitted by state or federal law; or (c) The Social Security Administration or a social security or vocational rehabilitation vendor. Reed Group and DePaul University may use information obtained pursuant to this authorization in any other claim matter they handle related to me.

I understand that this authorization is necessary for the processing of my claim or request for medical restrictions and that failure to sign this authorization may impair or impede the processing of my claim or request for medical restrictions. I understand my treatment provider will not base treatment, payment, enrollment or eligibility on the refusal to sign this authorization. However, I understand that such refusal may affect my eligibility for benefits under my employer's disability policy.

I understand that this authorization is valid until I submit written revocation to my employer or Reed Group. I hereby release any person or entity providing information from any and all liability for furnishing such information. I agree that a photographic or facsimile copy of this authorization is as valid as the original.

Printed Name of Patient:	**SSN:**
Signature of Patient or Patient's Representative:	**Date:**
Printed name of Patient's Representative and Relationship to Patient, if applicable:	