AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Social Security #: _____ Claim #: _____

I request and authorize **Sedgwick Case Management Service**

to release healthcare information of the patient named above to:

Union Representatives of Communications Workers of America

Employee's Name: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Patient Signature: _____ Date Signed: _____

Please Fax Completed Form to Sedgwick CMS at 866 224-4627