# Disability Management Program

## Long-Term Disability Authorization for Release of Medical and Other Information

***NOTE:*** *Release of your protected health information by medical providers consistent with the Health Insurance Portability and Accountability Act (HIPAA) requires your authorization. You are not required to sign the authorization, but if you do not, Reed Group may not be able to evaluate or administer your claim(s). Please sign and return this authorization to:*

Reed Group
P.O. Box 6248
Broomfield, CO 80021
Phone: 888-825-5247, option 5
Fax: 720-279-6783

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility or service; health plan; rehabilitation professional; vocational evaluator; insurance company; reinsurer; insurance service provider; third party administrator; producer; the Medical Information Bureau; GENEX Services, Inc., Allsup, Inc,; government organization; and employer that has information about my health, financial or credit history, earnings, employment history, or other insurance claims and benefits, including Social Security benefits, to disclose any and all of this information to persons who administer claims for Reed Group and duly authorized representatives (“Reed Group”). Information about my health may relate to any disorder of the immune system including, but not limited to, HIV and AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information Reed Group obtains pursuant to this authorization will be used to evaluate and administer my claim(s) for benefits, including any assistance in my return to work. I further understand that the information is subject to redisclosure and might not be protected by the HIPAA Privacy Rule.

This authorization is valid for two (2) years from the date below, or the duration of my claim, whichever is shorter. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent Reed Group has relied on the authorization prior to notice of revocation or has a legal right to contest a claim under the policy or the policy itself. I understand if I revoke this authorization, Reed Group may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). I may revoke this authorization by sending written notice to the address above.

I understand if I do not sign this authorization or if I alter its content in any way, Reed Group may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s).

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Claimant Signature ______________________ Date Signed ______________________

Print Name ______________________ Social Security Number) ______________________

I signed on behalf of the claimant as __________________ (Indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.