HIPAA Authorization for Release of Health Information

By my signature, I do hereby authorize and give permission to all healthcare providers who provide medical care or related services to me, to disclose any of my medical records or other protected health information (such as x-rays, diagnostic test results, MRI test results, physician narratives, physical therapy notes, prescription records and other medical reports) to the following persons duly acting on behalf of the Occupational Injury Plan (the "Plan): (1) the Executive Vice President of, and any claims adjuster, claims supervisor or authorized staff member for, Sedgwick, and (2) any other person designated by my Employer as Claims Administrator, Final Review Officer or Committee member for the Plan. My permission is also give to such healthcare providers and Plan representatives to fully discuss my diagnosis, treatment, condition, and prognosis. I further authorize such healthcare providers and Plan representatives to use and disclose such information for the purposes specified below to my employer, the McDonald's Owner Operator indicated below ("Employer"), and any medical case manager, repricing company, accounting or payroll representative, insurance agent, insurance carrier, consultant, or attorney.

I understand that the persons listed above will use and disclose my health information for the following purposes: (1) to evaluate and authorize treatment of any alleged injury while working at my Employer; (2) to make a determination of applicable benefits and make payment of Plan benefits, if any (including without limitation pre-authorization and concurrent review of my medical treatment); (3) the assessment of my ability to qualify for leave or return to full/modified duty; and (4) liability and safety evaluations.

By signing below, I understand and acknowledge that (1) this Authorization shall expire on the date upon which I am no longer eligible for Plan benefits; (2) I have a right to revoke this Authorization by contacting in writing my Employer - however, this revocation will not apply to any use or disclosure made prior to my Employer's receipt of my revocation; (3) the Plan may not condition treatment, payment, enrollment or eligibility for benefits solely on whether] sign this Authorization; (4) there is a potential that my protected health information used and disclosed in accordance with this Authorization may be redisclosed by certain persons receiving this information and may then no longer be protected by federal law; and (5) I am entitled to a copy of this Authorization. A photocopy of this Authorization shall be considered as effective as the original.

If Employee is under age 18, a parent or legal guardian must also sign below.

X_____ _____/_____/_____
Employee Signature Date

_____ _____-_____-_____ _____
Employee Name Printed Social Security Number Store Number

X_____ _____/_____/_____
Parent/Personal Representative Date
(If signed by a personal representative (such as a legal guardian), please describe the representative's authority to act for the Employee: _____)

_____
Name of Owner Operator Employer

Send this form with injured employee to your medical provider.