



AUTHORIZATION FOR RELEASE OF INFORMATION

STEP 1: COMPLETE ALL INFORMATION REQUESTED BELOW

Employee's First Name: Samuel	Employee's Last Name: Thomas	Claim Number:
Employee's Street Address: 70 W Clear Lake Lane		
Employee's City, State, Zip Code: Westfield, IN 46074		
Employee's Phone Number:	Employee's Date of Birth: 12-13-1972	Last 4 Digits of SSN: XXX-XX- <u>5584</u>
Employer Name: THE CAPITAL GROUP COMPANIES	Last Day Worked: <u>5/19/2020</u>	First Day Away from Work: <u>5/20/2020</u>

STEP 2: PLEASE READ THE FOLLOWING AUTHORIZATION FOR RELEASE OF INFORMATION

- **Authorization.** I authorize any physician, or other medical/treating practitioner, hospital, clinic, medical facility or service, pharmacy, pharmacy benefits manager, insurer, claims administrator, employer, group policy holder, or benefit plan administrator to disclose to Matrix Absence Management ("Matrix"), my employer in its capacity as administrator of its benefit plan(s), an insurer of any claim I assert, and any other authorized representative(s), and/or attorney representatives, any and all information about my health records, medical care treatment, employment, or my short-term disability, long-term disability, worker's compensation, leave of absence, accommodation, or other absence management program claim(s). In addition, I authorize Matrix to disclose to my employer, its affiliates, or other authorized representatives stated above, any and all information about my health records, medical care treatment, employment, and absence management claim(s) information.
- ***This authorization to obtain and disclose information about me, includes my permission to obtain and disclose the following:*** All of my medical and health information and records concerning my medical condition(s), disability, diagnosis, physical/mental health treatment, alcohol and substance abuse treatment, HIV related treatment, prescriptions, medical advice, facts, reports, diagnostic tests, x-rays, statements of charges, diagnoses, treatments rendered or recommended, prognoses, medications (prescription and over-the-counter), opinions of disability, charts, notes, correspondence, photographs, videos, digital images, films, and any

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other information relating to my medical condition, care, treatment, and/or evaluations, as well as any employment, payroll, tax, benefit, wages, or earnings information within their knowledge.

- **Purpose.** I understand this information will be used to determine my eligibility for the benefits or compensation to which I may be entitled under any benefit plan, policy, or practice of my employer or pursuant to any municipal, state, or federal leave or benefits law, or for other employment benefits, terms, conditions, obligations, rights, plans, or policies.
- **Voluntary authorization; no effect on treatment or other rights.** I am signing this Authorization voluntarily. I understand that treatment, payment, or my eligibility for benefits or other claims will not be affected if I do not sign this Authorization, although I understand that determination of my claim may be delayed and/or my claim may be denied if I do not fulfill my obligation to provide sufficient medical information to support my claim.
- **Revocation.** I understand that I may revoke this authorization at any time upon written notice to the address below. If revoked, the information described above may no longer be used or disclosed for the purposes described in this written authorization; however, any use or disclosure already made with permission cannot be undone.
- **Release of certain information.** I understand that if my claim relates to a psychiatric/mental illness, drug or alcohol treatment, or treatment for the Human Immunodeficiency Virus (HIV), that records regarding these conditions are protected records and it is my right not to allow access to these records. Understanding this, I wish to have these records released so that Matrix will have a full understanding of my medical condition and claims. If I do not wish to release such records, I may cross out and initial this paragraph.
- **Effect of disclosure or re-disclosure on HIPAA-protected information.** I understand that disclosure of the above-requested information may include disclosure of protected health information as defined by the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and applicable accompanying regulations. I further understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure to others by Matrix, my employer, or any of their authorized representatives and is no longer protected by the Privacy Rule of HIPAA. For more information, please see Matrix's privacy policy at:
<http://www.matrixcos.com/privacy&legal.html>
- ****IMPORTANT NOTICE:**** The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request

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for medical information. "**Genetic information**," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

STEP 3: INITIAL ALL PAGES AT THE BOTTOM, SIGN PAGE 3, AND RETURN ALL PAGES

I have read this authorization and understand it. Unless revoked, this authorization expires in one year or after the duration of my claim for benefits, whichever is earlier. A copy of this authorization is valid as an original.


Signature of Employee

5/20/2020

Date

STEP 4: IF EMPLOYEE/CLAIMANT IS UNABLE TO SIGN, A DESIGNATED REPRESENTATIVE MAY SIGN. PLEASE COMPLETE THE DESIGNATED REPRESENTATIVE INFORMATION

Name of Designated Representative (PRINT)

Signature of Designated Representative

Date

Description of authority to sign on behalf of above person:

STEP 5: PLEASE RETURN ALL PAGES TO:

Matrix Absence Management, Inc.
2421 W. Peoria Avenue, Suite #200
Phoenix, AZ 85029
FAX: (866) 683-9548

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