

AUTHORIZATION FOR RELEASE OF RECORDS

Instructions: This form must be completely filled out and mailed to the address below:

Employment Development Department P.O. Box 826880, MIC 53 Sacramento, CA 94280-0001

l,			, authorize the
	Type or Print Name		
Employment Development [Department to release	a copy of my medical recor	ds pertaining to
Specify type of Reco	ords – Example: Unemploymen	t Insurance Records, Disability Insuranc	e Records
For the period of:	through YY MM/DD/	to the	
following individual or entity	y (or its representative	!):	
Name of Individual/Entity (or its	s Representative)		
Address			
City, State, Zip Code			
otherwise specified. A copy		90 days from date of signato hall be as valid as the origina	
Date:	Signature		
	Social Security N	umber*	

^{*}Providing your social security number on this form is voluntary and if you provide your social security number, it will be used solely for the purpose of locating the requested records. If you choose not to provide your social security number, the Employment Development Department may be unable to locate any or all requested records due to the Employment Development Department's use of social security numbers for record identification and filing purposes.

Privacy Act of 1974 Section 7(b) (Public Law 93-579)