Employment Development Department
State of California

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

I, _____, authorize the
Type or Print Name

Employment Development Department to release a copy of my medical records pertaining to:

_____
Specify type of Records – Example: Unemployment Insurance Records, Disability Insurance Records

for the period of: _____ through _____ to the
MM/DD/YY MM/DD/YY

following individual or entity (or its representative):

_____
Name of Individual/Entity (or its Representative)

_____
Address

_____
City, State, Zip Code

This Authorization shall remain in effect for 90 days from date of signature or as otherwise specified. A copy of this Authorization shall be as valid as the original.

Date: _____ _____
MM/DD/YY Signature

_____
Social Security Number*

*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)