AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

This Authorization is being provided so that ReedGroup Absence Management and any of its parents, affiliates, subsidiaries, and/or third-party contractors can obtain the necessary information to administer a claim for leave benefits. Once this Authorization is completed and signed by the patient whose personal health information is to be disclosed, the health care provider should retain the original for its records and provide a copy of the Authorization to the patient who may either **fax a copy to**: (847) 554-1853 or mail it to: TIPP Customer Care at ReedGroup, P. O. Box 6278, Broomfield, CO 80021.

To: Any health care provider, employer, benefit plan, insurer, or federal, state, or local government agency, including the Social Security Administration and Veterans Administration. I give you permission to disclose to ReedGroup a complete copy of any and all of the following personal or privileged information, records, or documents relative to:

_____	_____	_____
Employee's Name (Printed)	Date of Birth	Employee ID

Any and all medical (but not genetic) information or records, including X-ray films, medical histories, physical, mental or diagnostic examinations, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health, as such information may be related to my claim for benefits; and **work information and history**, including job duties, earnings and personnel records, and client lists. The information obtained by use of this Authorization will be used to evaluate and administer my claim for benefits under my employer's benefit plans, and under any federal or state Family & Medical Leave Act or family military leave law. Such information is referred to in this Authorization as "My Information." I understand I have the right to revoke this Authorization for future disclosures, unless action has been taken in reliance upon this Authorization. I must revoke this Authorization in writing directly to ReedGroup.

I ALSO UNDERSTAND that once My Information has been disclosed to ReedGroup as permitted under this Authorization, it may be re-disclosed as permitted by law or my further authorization. I authorize ReedGroup to use or disclose My Information (i) to Employees Retirement System of Texas (ERS) for (a) functions related to accommodating my disability (if any); (b) responding to claims related to accommodation or adverse or discriminatory treatment related to my claim; (c) responding to any litigation or agency charge document production request or lawful subpoena; (d) federal or state Family & Medical Leave Act administration or state family military leave law administration; or (e) fulfilling fiduciary obligations under my benefit plan; (ii) to the administrator or other service providers of ERS' benefit plan or other benefit plans of my employer for plan-related functions; (iii) to any system used for claims processing or insurance broker to carry out functions related to my benefit plan or claim; (iv) to any health care professional who has treated or evaluated me or who may do so; (v) to other persons or entities performing business or legal services related my claim; (vi) as may be lawfully required; (vii) as I may further authorize; or (viii) as necessary to prevent or to detect perpetration of a fraud.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. I understand that I have the right to revoke this Authorization for future disclosures ReedGroup may make, unless they have taken action in reliance upon this Authorization. I must revoke this Authorization in writing directly to ReedGroup. I understand that my medical treatment or potential payment(s) for medical benefits cannot be conditioned on my allowing ReedGroup to re-disclose My Information. This Authorization expires two years from the date listed below, or upon my revocation, if earlier, but will not exceed the term of my coverage of the policy or benefit plan. I understand that I am entitled to receive a copy of this Authorization upon request. A photocopy or facsimile of this Authorization shall be as valid as the original. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

Important Information for Your Health Care Provider About GINA

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 an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request 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.

_____	_____
Signature of Patient or Personal Representative	Date Signed
_____	_____
Patient's Name (Printed)	Personal Representative's Name (Printed) and Relationship