APPLEBY & CO.
INC

EMPLOYMENT DEVELOPMENT DEPARTMENT
800 CAPITOL MALL, ROOM 5020, MIC 53
SACRAMENTO, CALIFORNIA 95814

AUTHORIZATION FOR THE RELEASE OF INFORMATION RELATED TO UNEMPLOYMENT INSURANCE CLAIMS AND BENEFITS AND/OR DISABILITY CLAIMS AND BENEFITS.

Name: _____ Date of Birth: _____

Social Security Number:_____

I hereby authorize: THE EMPLOYMENT DEVELOPMENT DEPARTMENT OF THE STATE OF CALIFORNIA

To disclose:_____

For the period _____to _____

This information is required for _____

I hereby authorize the Employment Development Department (EDD) to disclose information relating to any applications for and/or benefits received from the EDD related to Unemployment Insurance or Disability Insurance benefits programs.

I further authorize ***Appleby & Company, Inc.,*** a private company, to obtain a copy of such records as they are needed for the above stated purpose on behalf of (Name of Company engaging _____to obtain the records).

I have read the above and also have been advised of my right to receive a true copy of this authorization. Further, I understand the contents of this written authorization in its entirety and have asked questions about anything that was not clear to me, and am satisfied with the answers I have received. I further acknowledge that I understand my right to revoke this authorization by presenting written notice to _____who I have authorized to obtain said records prior to them submitting their request to the entity listed above.

I further understand that if ***Appleby & Company, Inc.*** has already served the authorization to the entity listed above, they have the right to dishonor my request to revoke the authorization.

It should be further noted that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient.

A PHOTOSTATIC OR FACSIMILE COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

Authorized Signature _____

Date _____

If you are not the individual, but a personal representative of the individual, please print your name and attach proof of the same to the authorization.

This authorization shall remain valid for one year from the above date.

Copy Furnished: YES☐ NO☐

IF APPLICABLE, PLEASE COMPLETE THE FOLLOWING:

I consent to the release of any and all records related to the treatment of, or diagnosis for, Drug, Alcohol, Psychiatric or HIV/Aids related conditions under the same terms as outlined above. I understand that such information cannot be released without my specific consent.

Signature of Patient: _____

Signature of person acting on behalf of patient: _____

Relationship to Patient: _____

(If an appointed Guardian, please attach documentation)

Date: _____