EMPLOYEE'S AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

State Form 50107 (R/12-03)

STATE OF INDIANA
State Personnel Department,
Benefits Division
Disability Program

Mail completed form to: JWF Specialty Co., Inc. (Third Party Administrator)
PO Box 40968
Indianapolis, IN 46240-0968
Telephone: (317) 803-7200 or (317) 574-7876
Fax: (317) 574-7865

To Whom It May Concern:

I, _____ *(employee's name),* hereby authorize any hospital, physician, medical practitioner, clinic, other medically related facility, pharmacy, or Government agency, to disclose or furnish to the State of Indiana, JWF Specialty Co.*, or its representatives, any and all information with respect to the illness *(including mental illness, drug / alcohol abuse)* or injury causing the disability, including consultations, prescriptions, treatments and copies of all applicable records that may be requested.

This information provided to the State of Indiana or its representatives is to be used solely for the administration of disability claim(s) as captioned above. A photostatic copy of this authorization is to be considered as valid as the original and is effective for the duration of the claim.

_____
Patient's or Authorized Person's Signature

_____
Authorized Person's Relationship

_____
Date *(month, day, year)*

* This authorization to release medical information to JWF Specialty Co. is only valid during the term of its contract with the State of Indiana.

Note: **A true copy of this authorization is available to the patient or the authorized representative at any time, upon request.**