PUBLIC SCHOOL RETIREMENT SYSTEM OF MISSOURI

PO Box 268
Jefferson City, MO 65102-0268
(573) 634-5290 or
Toll Free: (800) 392-6848
Fax: (573) 634-7934
Email: psrspeers@psrspeers.org
Website: www.psrs-peers.org

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Notice to Healthcare Provider: If a fee applies, please include a copy of the statement of your charges with the information requested. Any fee that will result in a total charge exceeding $200 must receive prior approval from PSRS. Please contact our office before processing this request.

SECTION A – MEMBER INFORMATION

Member's First Name	Member's Middle Name	Member's Last Name	
Member ID	Last Four Digits of Member's Social Security Number	Account ID	Member's Date of Birth
Mailing Address			
City	State	ZIP	Telephone ( )
Email Address			

SECTION B – PATIENT AUTHORIZATION

I hereby authorize the physician/facility below to release to the Public School Retirement System of Missouri (PSRS) any and all information acquired as a result of examination or treatment of me to be used for the purpose of determining my eligibility for disability retirement. I further waive all provisions of law forbidding release of information by an attending or examining physician.

Physician/Facility Name		
Mailing Address		
City	State	ZIP

Time Limit and Right to Revoke Authorization: Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the above named physician/facility. Unless revoked, this authorization will expire on the following date or event, or one year from date of signature, unless otherwise specified.	Date or Event of Expiration:

SECTION C – INFORMATION TO BE RELEASED

Information to be released covering the periods of health care for the dates below.

From (date):	To (date):

Please check type of information to be released:

☐	Complete Health Record	☐	Lab Test Results	☐	Operative Report(s)	☐	History and Physical
☐	Consultation Report(s)	☐	X-Ray Report(s)	☐	Progress Note(s)	☐	ER Report(s)
☐	Discharge Summary	☐	Medication(s)	☐	Pathology Report(s)	☐	Treatment(s)

Other (Specify)

Drug and/or Alcohol Abuse and/or Psychiatric Release: I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. **Check one:** ☐ Yes ☐ No

HIV/AIDS Records Release: I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release. **Check one:** ☐ Yes ☐ No

SECTION D – MEMBER SIGNATURE

Re-Disclosure: I understand that if I authorize release of my Protected Health Information to a person or organization that is not subject to federal law governing privacy, and that person or organization re-discloses my Protected Health Information, my Protected Health Information may no longer be protected by federal privacy laws.

Signature of Member (REQUIRED) **X**	Date