PUBLIC EDUCATION EMPLOYEE
RETIREMENT SYSTEM OF MISSOURI

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

SECTION A – MEMBER INFORMATION

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

SECTION B – HIPAA AUTHORIZATION FOR CARE PROVIDERS AND CONSULTANTS

I hereby authorize the use and disclosure of protected health information (PHI) about me for the purpose of my application for PEERS disability benefits as described below.

- The following specific person/class of person/facility is authorized to disclose PHI about me to PEERS and its Medical Advisor, Managed Medical Review Organization (MMRO): Any health care provider, hospital, medical facility, clinic, laboratory, rehabilitation center, or similar organization.
- The following person, class of persons, or entity may receive disclosure of PHI about me: PEERS, MMRO, any independent medical examiners and consultants retained by PEERS or MMRO.
- The following PHI may be disclosed: All records and other information with respect to any physical or mental condition or treatment of me, including, but not limited to, information regarding AIDS/HIV infection or treatment, communicable diseases, alcohol/substance abuse and treatment, mental health/psychiatric care, and gene-related impairments (including genetic test results).

SECTION C – AUTHORIZATION FOR PEERS AND MMRO TO RELEASE INFORMATION

I authorize PEERS and MMRO to provide PHI and other information on my disability file to any independent medical reviewer/examiner/consultant retained by PEERS or MMRO. I understand that such information may ultimately be used by the PEERS/PEERS Board of Trustees and circuit/appellate court judges in the event of any Board appeal or litigation related to my disability retirement application.

SECTION D – MEMBER SIGNATURE

- Except to the extent that action has already been taken in reliance on this authorization, I understand that I may revoke this authorization by notifying PEERS in writing of my desire to revoke it.
- This authorization expires one year from the date of my signature or upon the final determination of my eligibility for PEERS disability benefits, whichever is later. I authorize the use of a copy (including an electronic copy) or facsimile of this form.
- I understand that if I authorize release of my PHI to a person or organization that is not subject to federal law governing privacy, and that person or organization re-discloses my PHI, my PHI may no longer be protected by federal privacy laws.
- I understand that I have the right to request a copy of this authorization.

I certify that I have read, understand and agree to the above authorizations to release information.

Signature of Member (REQUIRED)	Date
X	