



**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.psr-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:

<input type="checkbox"/>	Complete Health Record	<input type="checkbox"/>	Lab Test Results	<input type="checkbox"/>	Operative Report(s)	<input type="checkbox"/>	History and Physical
<input type="checkbox"/>	Consultation Report(s)	<input type="checkbox"/>	X-Ray Report(s)	<input type="checkbox"/>	Progress Note(s)	<input type="checkbox"/>	ER Report(s)
<input type="checkbox"/>	Discharge Summary	<input type="checkbox"/>	Medication(s)	<input type="checkbox"/>	Pathology Report(s)	<input type="checkbox"/>	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