PUBLIC SCHOOL 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 PSRS disability benefits as described below.

- The following specific person/class of person/facility is authorized to disclose PHI about me to PSRS 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: PSRS, MMRO, any independent medical examiners and consultants retained by PSRS 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 PSRS AND MMRO TO RELEASE INFORMATION

I authorize PSRS and MMRO to provide PHI and other information on my disability file to any independent medical reviewer/examiner/consultant retained by PSRS or MMRO. I understand that such information may ultimately be used by the PSRS/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 PSRS 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 PSRS 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) **X**	Date