RD-1183-0826

State of New Jersey • Department of the Treasury

PFRSNJ DISABILITY RETIREMENTS

P.O. Box 297, Trenton, NJ 08625-0297

AUTHORIZATION FOR RELEASE OF INFORMATION (HIPAA)

Name of Applicant _____
First *Last* *MI*

Date of Birth _____/_____/_____ Pension Number _____

This Authorization is intended to comply with the HIPAA Privacy Rule

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility,employer or other health care provider that has provided treatment, payment, or services to me or on my behalf ("my providers") to disclose my entire medical record and any other health information concerning me to the Police and Firemen's Retirement System of New Jersey, and it's agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, and includes psychotherapy notes.

I authorize all non-health organizations, any insurance company, employer, or other person or institutions to provide any information, data, or records relating to credit, financial, earnings, travel, activities, or employment history to the Police and Firemen's Retirement System of New Jersey.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct my providers to release and disclose my entire medical record without restriction.

This information is to be disclosed under this Authorization so that the Police and Firemen's Retirement System of New Jersey may conduct legally permissible activities that relate to 1) my claim for retirement benefits, 2) my awarded retirement benefits, 3) my application for retirement benefits, and 4) any application, claim or award for retirement benefits filed by an individual/member involved in the incident(s) upon which I have applied for a retirement benefit.

This Authorization shall remain in force for 24 months following the date of my signature below, except to the extent that state law imposes a shorter duration. A copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to the Police and Firemen's Retirement System of New Jersey I understand that a revocation is not effective to the extent that any of my providers has relied on this Authorization or to the extent that the Police and Firemen's Retirement System of New Jersey has a legal right to contest a claim for benefits. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this Authorization to release my complete medical record, the Police and Firemen's Retirement System of New Jersey may not be able to process my claim for benefits. I understand that I have a right to request and receive a copy of this Authorization.

_____ _____/_____/_____
Signature *Date*

Return this application to:

PFRSNJ Disability Retirements
P.O. Box 297
Trenton, NJ 08625-0297