



46 State House Station
 Augusta, ME 04333-0046
 Telephone: (207) 512-3100
 Toll-free: 1-800-451-9800
 TTY: (207) 512-3102

CONSENT FORM AUTHORIZING RELEASE OF INFORMATION

Member Name:

Prefix	First	MI	Last	Suffix

Last Four Digits of Social Security Number: Date of Birth:

mm	dd	yyyy

I authorize Maine Public Employees Retirement System (MainePERS) to obtain from all treating providers and facilities; any physician, or health care provider who has treated me, all related information (including copies of all applicable records) regarding any illness, injury, prescriptions, treatments, consultations, or other medical history pertaining to the following condition(s): _____

_____*

These disclosures are necessary to determine my eligibility for disability retirement benefits from MainePERS. This consent will expire 12 months from the date of my signature below.

This release also grants the special authorization needed to release medical records pertaining to me under the Drug Abuse Office and Treatment Act of 1972 and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendment of 1974.

I DO/DO NOT (circle one) authorize disclosure of information which refers to treatment or diagnosis of drug or alcohol abuse, the diagnosis of psychiatric illness or information which refers to treatment of HIV and related diseases.

I understand that I may refuse authorization to disclose all or some health care information, and that my refusal may result in the denial of my application for benefits from MainePERS. I understand that this authorization may be revoked at any time by me. I understand that revocation may result in the denial of my application for benefits from MainePERS. In order to revoke, I would need to execute a written revocation, subject to the right of any person who acted in reliance on this authorization prior to receiving notice of the revocation. I understand that this authorization may be revoked by mailing or hand delivering a notice to that effect to the following address:

Disability Program, MainePERS, 46 State House Station, Augusta, Maine 04333-0046

The revocation will be effective on the date received at MainePERS. I further understand that revocation may be the basis for a denial of disability retirement benefits.

I further authorize the release of any information obtained by MainePERS to any and all agents, servants, and employees of MainePERS acting on behalf of MainePERS in connection with my application for disability retirement benefits, including, but not limited to, consulting physicians, psychiatrists, psychologists and other health care providers, rehabilitation service providers, attorneys/advocates of MainePERS and members of the MainePERS Board of Trustees.

A photocopy of this release will be as valid as the original. I understand that I am entitled to a copy of this authorization.

 Signature _____
Date

***NOTE TO HEALTH CARE PROVIDERS:** It is important to realize that any information you send to us, including your office notes, may be released to the person executing this authorization or to his or her representative, upon request. Disclosure might occur, for example, if the record you send us is considered in connection with an application for disability retirement benefits and during any appeal proceedings, particularly those appeal proceedings which are open to the public. If you have reason to believe that the release of the information you send us might be harmful to the person executing this authorization in any way, or if you have another basis upon which complete confidentiality should be maintained, you must state so in a letter included with the records sent to the attention of the Disability Program. Your letter should clearly and fully inform us why the information should not be disclosed. Please note that form language stamped on or attached to the information prohibiting redisclosure will not be sufficient to maintain the complete confidentiality of the records.