maine PERS Public Employees Retirement System
P.O. Box 349
Augusta, ME 04332-0349
Telephone: (207) 512-3100
Toll-free: 1-800-451-9800
Fax: (207) 512-3285
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 any and all information contained in the medical record from all treating providers and facilities (including copies of all applicable records) regarding any illness, injury, prescriptions, treatments, consultations and medical opinions relating to diagnosis, care and treatment of:
(LIST CONDITION(S) HERE:) _____
_____.*

ADDITIONAL AUTHORIZATION:

I ❑ do ❑ do not 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.

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

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, or current eligibility 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, or current eligibility 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 Service Division, MainePERS, P.O. Box 349, Augusta, Maine 04332-0349

The revocation will be effective beginning on the date received at MainePERS.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

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, or appeal, 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, Board Counsel 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.

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.

_____ _____
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.