

# Retirement Board Authorization to Use or Disclose Protected Health Information

1. I hereby authorize: \_\_\_\_\_  
(physician, hospital, insurance company, employer, other health/rehabilitation entity)  
to use or disclose the following protected health information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to Federal or State law protecting its confidentiality. Information released on this authorization, if redisclosed by the recipient, is no longer protected.

2. Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

3. Information to be disclosed to: \_\_\_\_\_ Retirement Board

Enter Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Please check the box below to authorize release of your complete medical record, **or**, use the lines below to stipulate any exceptions.

Authorize Release of Complete Medical Record

Exceptions: \_\_\_\_\_  
\_\_\_\_\_

5. I have checked the box below indicating the purpose for the disclosure of this information.

Disability Retirement Application: (G.L. c.32, §6 & §7)

Restoration to Service Evaluation (including rehabilitation): (G.L. c.32, §8)

Accidental Death Benefit: (G.L. c.32, §9 & §100)

6. I understand I may revoke this authorization at any time by notifying the Retirement Board in writing, unless action has already been taken in reliance upon it, or during an appeal under the applicable law.

7. This authorization will expire upon final determination of my disability application or Comprehensive Medical Evaluation/Rehabilitation/Restoration to Service process or up to one year from date signed below.

8. \_\_\_\_\_  
Signature of Patient or Legal Representative

10. \_\_\_\_\_  
Date

9. \_\_\_\_\_  
Printed Name of Patient or Patient's Representative

\_\_\_\_\_  
Relationship to Patient/Authority to Act for Patient if Applicable

**All numbered entries must be completed for this authorization to be valid.**

**Please note, Retirement Boards are not covered entities under the Health Insurance Portability and Accountability Act (HIPAA), however all information is treated in a confidential manner consistent with Federal and State privacy laws.**

(Over)

## How This Information is To Be Used

Pursuant to Massachusetts General Laws, Chapter 32, sections 6 and 7, the Public Employee Retirement Administration Commission (PERAC) is responsible for appointing regional medical panels to evaluate members seeking Disability Retirement. During the application process the Retirement Board and PERAC may obtain, share, and disclose information as necessary to complete the Disability Retirement process.

Pursuant to Massachusetts General Laws, Chapter 32, section 8, PERAC is also responsible for conducting Comprehensive Medical Evaluations (CME), offering Rehabilitation, and scheduling Restoration to Service (RTS) examinations, to determine if the member is able to perform the essential duties of his/her former position, with or without rehabilitation. During this process, the Retirement Board and PERAC may obtain, share, and disclose information as necessary to complete this evaluation process.

The information used/shared/disclosed during the four phases of the Disability process may include information provided by physicians, hospitals, insurance companies, employer, and other health/rehabilitation entities.

Please note, this original authorization form may be copied and reissued for the purpose of gathering and sharing protected information necessary to the Disability Application, CME, Rehabilitation, and RTS examinations.
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