RD-0998-0818

State of New Jersey • Department of the Treasury

DIVISION OF PENSIONS & BENEFITS — RETIREMENT SECTION

P.O. Box 295, Trenton, NJ 08625-0295

AUTHORIZATION FOR RELEASE OF INFORMATION (HIPAA)

Pension Number _____

Name of Applicant _____
First *Last*

Date of Birth _____ /_____ / _____
Month *Day* *Year*

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 State of New Jersey, Division of Pensions & Benefits, 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 State of New Jersey, Division of Pensions & Benefits.

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 State of New Jersey, Division of Pensions & Benefits 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 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 State of New Jersey, Division of Pensions & Benefits P.O. Box 295, Trenton, New Jersey 08625. 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 Division of Pensions & Benefits 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 Division of Pensions & Benefits 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.

_____ _____
Date *Signature*

Return This Form To:

New Jersey Division Of Pensions & Benefits
Disability Retirement Section
P.O. Box 295
Trenton, NJ 08625-0295