

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Section A: Member information

Name: First, MI, Last, suffix (Jr. III, etc.)		Social Security Number										
Street Address / Post office box	Home telephone	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>										
City, State, ZIP code	Alternate telephone:	Date of birth										
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Section B: Explanation

Please complete this form if you would like to have Ohio Police & Fire Pension Fund (OP&F) provide copies of your medical records that are on file with OP&F to you, your designated agent, or your personal attorney or physician. OP&F cannot release copies of these records to any other person or entity, as provided in Ohio Revised Code Section 742.41(C) and Rule 742-7-02(C) of the Ohio Administrative Code. Any release of medical records will be made in accordance with these governing provisions.

Section C: Request and authorization to release medical records

I request and authorize OP&F to send copies of my medical records that are on file with OP&F to:

Please check one: Me My designated agent My attorney My physician

If records are to be sent to your designated agent, your personal attorney or physician, please complete that person's information below.

Name: First, MI, Last, suffix (Jr. III, etc.)	Organization/Title:
Street Address / Post office box	Home telephone
City, State, ZIP code	

Section D: Signature and acknowledgement

I, the member described in section A of this *Authorization to Release Medical Records* form, who, having been duly sworn, hereby authorize OP&F to release copies of my medical records to the person named in Section C of this form, and I waive my rights to any claim against the Ohio Police & Fire Pension Fund, its employees or the Board of Trustees which may result from the release of this information.

Signature: 	Date of signature:
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Section E: Notary public requirement

The notary public in good standing must sign in the space provided in this section and affix their seal.

State of _____, County of _____, ss:

The foregoing *Authorization to Release Medical Records* form was acknowledged before me by the person named in the foregoing Section A, this _____ day of _____, 20_____.

Affix Seal here	Notary's signature:
	Print name:
	My commission expires: