Authorization to Disclose Protected Health Information

888 CalPERS (or 888-225-7377) • TTY: (877) 249-7442 • Fax: (800) 959-6545

Section 1 Member Information

Name of Member (First Name, Middle Initial, Last Name)

Social Security Number or CalPERS ID

Birth Date (mm/dd/yyyy)

Section 2 Purpose of Authorization

The purpose for this authorization is to determine a physical or mental condition, illness, or disability and the right, if any, to retirement, reinstatement, or other benefits under the Public Employees' Retirement Law (PERL) (Government Code sections 20000, et seq.) and the Public Employees' Medical and Hospital Act (PEMHCA) (Government Code sections 599.500, et seq.).

I, _____ (Name of Member or Authorized Representative), hereby authorize _____ (Name of Health Care Provider/Facility or Physician) to disclose protected health information to the California Public Employees' Retirement System (CalPERS) or its representative relating to _____ (Name of Member or Disabled Dependent).

This authorization applies to any and all health and/or medical related information, including the following:

Medical histories, diagnoses, examination reports, chart notes, testing and test results, X-rays, operative reports, lab and medication records, prescriptions, and any other records relating to the prognosis, treatment, or diagnosis of any condition.

Treatment records from mental health departments, alcohol/drug departments, or HIV antibody tests are specifically protected. I authorize the release of the following by my initials and signature:

_____ Mental health department records

_____ Alcohol/drug dependency treatment records

_____ HIV antibody test results

Signature of Member or Authorized Representative

Date (mm/dd/yyyy)

Dates of service for which I am authorizing release of information: From _____ (mm/dd/yyyy) to the present.

Expiration of Authorization:
Unless canceled by me in writing, this authorization shall be valid for four years from the date shown below. A photocopy of this authorization shall be as valid as the original.

Put your name and Social Security number or CalPERS ID at the top of every page.

Your Name | Social Security Number or CalPERS ID

Section 3 Acknowledgment and Signature

I acknowledge and understand the following:

- I authorize the use and/or disclosure of the individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary.
- I have the right to receive a copy of this authorization.
- I have the right to revoke this authorization at any time by sending a signed notice to CalPERS at the address below. The authorization will cease on the date my valid revocation release is received.
- This authorization may not be revoked if CalPERS has acted in reliance thereon, or the authorization was obtained as a condition of obtaining insurance coverage.
- Under California law, the recipient of my medical information is prohibited from re-disclosing the information, except with a written authorization or as specifically required or permitted by law.
- My treatment, payment, enrollment, or eligibility for benefits will continue to be subject to current policies and regulations if I do not sign this authorization.
- If the organization or person I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Signature of Member or Authorized Representative* | Date (mm/dd/yyyy)

*If this is a request from the Authorized Representative, please attach the member's written authorization or a copy of the applicable Power of Attorney or conservatorship document(s) when returning the form.

Mail to: **California Public Employees' Retirement System** • P.O. Box 942715, Sacramento, California 94229

Privacy Notice

The privacy of personal information is of the utmost importance to CalPERS. The following information is provided to you in compliance with the Information Practices Act of 1977 and the Federal Privacy Act of 1974.

Information Purpose

The information requested by CalPERS' Information Security Office is collected pursuant to the following authority:

- CA Civil Code §56.10
- CA Civil Code §56.11
- CA Civil Code §56.13
- 45 C.F.R. §164.508

The principal purpose the information will be used for is the administration of duties under the Health Insurance Portability and Accountability Act (HIPAA), as the case may be. Submission of the requested information is mandatory. Failure to comply may result in the system being unable to process your request.

Please do not include information that is not requested.

Social Security Numbers

Social Security numbers (SSN) are collected on a mandatory and voluntary basis. If this is CalPERS' first request for disclosure of your SSN, then disclosure is mandatory. If your SSN has already been provided to CalPERS, disclosure is voluntary. Due to the use of SSNs by other agencies for identification purposes, we may be unable to process your request without its disclosure.

Social Security numbers are used for the following purposes:

1. Member / Representative identification
2. Fulfill Member / Representative requests

Information Disclosure

Portions of this information may be transferred to other state agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

Your Rights

You have the right to review your membership files maintained by the system. For questions about this notice, our Privacy Policy (https://www.calpers.ca.gov/page/privacy-policy), or your rights, please write to:

CalPERS
CalPERS Privacy Officer
400 Q Street
Sacramento, CA 95811

You may also call us at **888 CalPERS** (or **888**-225-7377).