AUTHORIZATION: RELEASE OF ACCOUNT INFORMATION

Ohio Public Employees Retirement System
277 East Town Street, Columbus, Ohio 43215-4642
1-800-222-PERS (7377)
www.opers.org

Ohio retirement law prohibits the release of confidential account information to a third party unless written authorization is provided by the member or retiree. You or the third party must contact OPERS separately to request account information. This form cannot be used to initiate a request for information. This form will not authorize access to a member's or retiree's online account. Use this form to authorize the release of account information as described below.

This form will not authorize the release of Protected Health Information (PHI) (re: a retiree or dependent's health care coverage). If you wish to authorize the release of PHI, please contact OPERS to request the HIPAA Authorization Form.

STEP 1: Member Personal Information

Social Security Number

___ — ___ — ____

-OR-

OPERS ID

Date of Birth

__ __ / __ __ / ____

First Name | MI | Last Name

Address

City | State | ZIP Code

Home Phone Number

___ — ___ — ____

Work Phone Number

___ — ___ — ____

Cell Phone Number

___ — ___ — ____

E-mail Address

See next page

STEP 2: Type of Information to be Released

This information will only be released when you or the third party contact OPERS separately to request account information. Select the records you wish OPERS to release to those you list in Step 3. You can contact OPERS separately by attaching a specific request to this form or by contacting OPERS at 1-800-222-7377 with your request after this form has been received and validated.

☐ Any/all account information (written and oral, excluding health care information)

☐ Service credit ☐ Contributions ☐ Earnable salary ☐ Value of account ☐ Breakdown of benefits

☐ Estimate of retirement benefits ☐ Income verification ☐ Form 1099-R ☐ Disability medical records

STEP 3: Person(s) or Entity(ies) to Receive Information

Complete this Section to designate the person(s) or entity(ies) to receive the information indicated in Step 2. If you wish to designate more than this step allows, list them on a separate sheet of paper and include their address, phone and fax number.

☐ If you are using additional pages, please check this box.

1. ◯ Physician ◯ Attorney ◯ Authorized Agent

First Name MI Last Name

Address

City State ZIP Code

Phone Number Fax Number

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2. ◯ Physician ◯ Attorney ◯ Authorized Agent

First Name MI Last Name

Address

City State ZIP Code

Phone Number Fax Number

See next page

STEP 4: Member Authorization

As permitted by Ohio Revised Code Section 145.27 and Ohio Administrative Code 145-1-61, I authorize the person(s) or firm(s) listed to request and receive the indicated information pertaining to my account with OPERS.

This authorization is good (select one):

◯ For 60 days ◯ For 90 days ◯ Indefinitely ◯ Until: ___ ___ / ___ ___ / ___ ___ ___ ___

If a date is not specified, the authorization will be good for 60 days from the date it was signed.

I ask that you honor copies or faxed transmissions of this authorization form. I acknowledge that additionally the original must be sent to OPERS for its membership records. I authorize OPERS to release the data indicated on this form to the person/organization indicated. I understand that I may provide written revocation of this authorization at any time prior to the authorization's expiration as provided above. I understand that this authorization will automatically expire upon my death.

I understand that medical records can be released only to my physician, attorney, or agent or the OPERS Board of Trustees' physician, per Ohio retirement law.

Member Signature _____ Today's Date ____/____/____

Do not print or type name