HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AUTHORIZATION FORM

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

This form is to authorize your health care providers to disclose your medical records to the Ohio Public Employees Retirement System (OPERS) and OPERS' third-party administrator Managed Medical Review Organization (MMRO) for the purpose of determining your initial or ongoing eligibility for disability benefits.

STEP 1: Member's Personal Information

This section is required to be completed or the form will be invalid.

OPERS ID

First Name | MI | Last Name

Date of Birth

STEP 2: HIPAA Authorization

This section is required to be completed or the form will be invalid.

- By signing below, I authorize any health care provider who has provided medical treatment to me, including but not limited to a physician, medical facility, or other provider of health care services or similar entity, to release the following medical information to OPERS or MMRO:

  all medical records and other information about me which relates to the diagnosis or treatment of any physical or mental condition, including but not limited to confidential information regarding AIDS/HIV infection, communicable diseases, alcohol and substance abuse, and mental health, as requested by OPERS or MMRO. Psychotherapy notes are not included in this authorization.

- Health care providers may, upon receipt of a request from OPERS or MMRO, disclose the information and records described above to a representative of OPERS or MMRO.

- The information described above will be used by OPERS and MMRO to determine your eligibility to receive disability benefits from OPERS, including but not limited to the determination of initial eligibility for disability benefits, whether current eligibility for disability benefits should continue, whether you can return to work, and to assess ongoing treatment needs.

See next page

STEP 2: HIPAA Authorization (continued)

- You are not required to sign this authorization form in order to receive treatment from a health care provider, or for your health plan to pay for treatment covered by the health plan. However, the information described above is required for OPERS to determine your eligibility for disability benefits, and your failure to sign this form may result in your application for disability benefits or your continuing eligibility for disability benefits being denied.

- OPERS is not a health care provider or health plan covered by HIPAA privacy regulations, and once disclosed, the information described above will no longer be protected by the HIPAA privacy regulations. However, OPERS will continue to maintain the information described above in a confidential manner and will use or further disclose it only as necessary to determine your eligibility for disability benefits and otherwise review your eligibility for disability benefits on an ongoing basis.

- You may revoke this authorization in writing at any time, except to the extent that action has been taken by a health care provider in reliance on this authorization, by sending a written revocation to Ohio Public Employees Retirement System 277 E. Town Street Columbus, OH 43215.

- This authorization will expire on the date you are no longer eligible to receive disability benefits from OPERS.

Member Name _____
PLEASE PRINT

Name of personal representative (if applicable) _____
PLEASE PRINT

Relationship of personal representative to member _____
PLEASE PRINT

Signature of Member (or member's personal representative)_____
DO NOT PRINT OR TYPE

Date of Signature _____

If this form is signed by a personal representative please describe the basis of the personal representative's authority to sign and attach any relevant documents (e.g., a power of attorney, Letters of Guardianship, court order, etc.)

_____
_____
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OPERS